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Establishing a Family Health Fund in Alexandria, Egypt: The Quality Contracting Component of the Family Health Care Pilot Project

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Prepared by:

Alan H. Edmond, M.P.A.
Consultant
Abt Associates Inc.

Mary A. Paterson, Ph.D.
Abt Associates Inc.

Ahsan J. Sadiq, M.A., M.P.A.
Consultant
Abt Associates Inc.

Linda Mitz Sadiq, M.B.A.
Consultant
University Research Co., LLC

Susan Scribner, M.P.P.
Abt Associates Inc.

Nena Terrell
Abt Associates Inc.

Partnerships for Health Reform
PHR

Abt Associates Inc. ■ 4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 ■ Tel: 301/913-0500 ■ Fax: 301/652-3916

In collaboration with:
Development Associates, Inc. ■ Harvard School of Public Health ■
Howard University International Affairs Center ■ University Research Co., LLC

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Abstract

The Family Health Fund (FHF) is an essential component of the Egyptian health sector reform program's pilot project for family care. It separates the purchaser and provider functions within a new health insurance system, and assumes the role of a quality contracting agency that will enter into agreements to purchase health services from providers.

This paper outlines steps necessary to establish the FHF in Alexandria and describes the steps already taken toward that goal. It discusses the process for managing change and issues that may impede change. It presents three institutional options for the location of the FHF and recommends an internal organizational structure and operational principles. The paper describes the critical role of the performance-based contracting and provider incentive payment functions of the FHF in supporting and sustaining high-quality family health care. The paper discusses the importance of the FHF management information system in administering the contracting system as well as providing data for monitoring, evaluation, cost analysis, and overall effectiveness. FHF communications and marketing activities are described with respect to their responsibilities to patients, providers, and the general public. The paper uses a conceptual framework for a policy process to discuss issues and approaches related to strategic policy planning and development for the FHF, as it evolves to become the financing agency within a full functioning health insurance system.

Table of Contents

List of Tables

List of Figures

Acronyms

FHC	
FHF	Family Health Fund
FHF-	Management Information System for the Family Health Fund
FP	
GOE	Government of Egypt
	Health Insurance Organization
HPSP	
MIS	Management Information System
	Ministry of Health and Popul
NGO	Non-
NICHP	National Information Center for Health and Population
	National Technology Laboratory
PHR	
QI	Quality Improvement
	Technical Support Office of the MOHP
TST	Team of the MOHP in Alexandria
	United States Agency for International Development

Acknowledgments

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We are also grateful to Dr. Hassan Abdel Fattah, chairman of the Egyptian Health Insurance Organization, for his confidence in us as we created proposals for the organization of the FHF. Dr. Hassan facilitated the process of establishing the FHF by establishing an Advisory Committee at the HIO North West Delta Branch to meet regularly with the PHR health insurance adviser and his support staff. He also nominated Dr. Refaat Sakr to be interim director of the FHF, providing a focal point for some of the discussions leading to the establishment of the FHF. Dr. Refaat's assistance is gratefully acknowledged. Thanks are also due to Dr. Mostafa Abdel Atti, former director of the HIO North West Delta Branch, for his decisive approach to resolving issues relating to the FHF.

All the members of the HIO Advisory Committee—Dr. Hazim Helmy (director of the HIO North West Delta Branch), Dr. Refaat Sakr, Dr. Sami Shehab, Dr. Nabil Gonah, Dr. Sonia Hanna, and Dr. Hoda Bakri—have worked tirelessly with us to develop concepts and strategies for the establishment and operations of the FHF. In addition to its contribution to progress on development of the FHF, the HIO Advisory Committee has been a model for cooperative problem solving with an enthusiastic commitment to results.

Other contributors to the success of this initiative are Dr. Hassan Abou Zeid, acting undersecretary of Health and Population, Dr. Mahmoud Khedr, former undersecretary of Health and Population, Dr. Salwa Seewi, HIO, Mr. Mohamed Abdel Hamid, HIO, Mr. Mohamed El-Gonaimy, HIO, Dr. Abdel Moneim Ebeid, TSO, Mr. Sami Farag, TSO, Dr. Amal Shokeri El Tahawi, TSO, Dr. Mahmoud Abdel Latif, TSO, Dr. Mahdeya Aly, director Technical Support Team, Dr. Nader Fatouh, MOHP, Dr. Hanaa Abdou Mansour, MOHP, Dr. Hanem El Abassy, director, Seuf Family Health Center, and Dr. Mohamed El. Lakani, director, HIO Abu Qir Family Health Unit.

Executive Summary

The government of Egypt (GOE) has begun an extensive, long-term program of health sector reform, one component of which is a shift from inpatient care to outpatient care, and from specialist care to primary health care and family medicine. Integral to the sustainability of this new service delivery model—currently being piloted in the Alexandria governorate—is a proposed financing and contracting component, called the Family Health Fund (FHF). Just as the new family medicine model will decrease fragmentation in the delivery of care, the FHF will ensure sustainability of the model through its incentive-based payments that encourage provider efficiency and quality. Ultimately, these two components of reform will expand access to care for all Egyptians.

The early achievements of the service delivery component at the Seuf pilot site are encouraging, but also, perhaps, misleading. Seuf's success in reforming its operational system is impressive when compared to existing Ministry of Health and Population (MOHP) urban health units. Nevertheless, this success led many health professionals to believe that the service delivery accomplishments at Seuf could simply be duplicated in the rest of the pilot governorate—without attention to financing reform.

This report intends to facilitate decision making about the financing reform by policymakers in the Egyptian MOHP. It summarizes the findings of many reform activities that have already taken place; describes the steps that are essential to establishing the FHF; lays out options for structuring, staffing, and operationalizing the fund; and discusses challenges that could impede FHF design and implementation.

The report also describes the support and advice that the Partnerships for Health Reform (PHR), a United States Agency for International Development (USAID)-sponsored project, has offered to the MOHP. PHR is the international donor with primary responsibility for the reform benchmark of establishing a financing entity of the health care pilot project.

The rest of this executive summary outlines the organization of the report.

Chapter 1: Background

The Egyptian Health Sector Reform Program, a 10- to 15-year process begun in the mid-1990s, was initiated by the GOE with the assistance of a number of donor agencies, such as:

> USAID, which is contributing $60 million over the first four years of the reform period;

> The World Bank, providing a loan of $90 million;

> The European Community, contributing $120 million; and

> The African Development Bank, contributing $13–14 million.

As the local share, the GOE will contribute $100 million.

Historically, the Egyptian health care system emphasized inpatient, institutional care. Reform efforts introduced by His Excellency, the Egyptian Minister of Health and Population, shift this emphasis toward outpatient, high-quality primary health care. This shift dovetails with the USAID goal of improving the effectiveness of health care delivery as a measure of overall health reform progress; to this end USAID has obligated approximately half of its resources for health care in Egypt into the primary care pilot project.

The Minister chose Alexandria governorate as the site for the pilot effort. Activities started with some service delivery pilot sites in the Montazah district; they will eventually expand to the entire district and thereafter to the entire governorate. Four types of provider facilities participate in the pilot: MOHP, Health Insurance Organization (HIO), private, and non-governmental organization (NGO). The lessons from the pilot in Alexandria are expected to be used for expansion to two other pilot governorates, Sohag and Menoufia. Eventually the program will be expanded to the whole country.

The Alexandria pilot project will ultimately comprise the following three components:

> A health care model that provides high-quality primary care services at sites comprehensively staffed with family practice physician/nurse teams and with the administrative capability to manage patient intake and establish and collect user payments.

> A financing component administered by a quality-contracting agency that pays performance-based incentives to providers. The Family Health Fund, which will serve as the quality contracting agency, will rely on systematic payment for services, skillful application of data collection and analysis, monitoring of both its own performance and that of service delivery sites, and control over referrals.

> A regulatory component of reforms for finance, accreditation, information, and contract management that each participating health care agency and provider must meet. Processes and approval mechanisms (including legal, regulatory, and institutional development) have been set up for the MOHP to enable the FHF to become a true financing entity, in concert with USAID's benchmarks and the MOHP's reform goals.

Chapter 2: Managing the Change Process

Chapter 2 describes the process for managing change, relevant stakeholders and their roles in FHF development, steps taken to build support for the FHF among those stakeholders, and suggestions for improving the effectiveness of the approaches used.

Change is a process, not a single event. Implementation of health reform is an extremely complex change process in which certain dynamics are inherent and predictable, including resistance to reform. Those leading reform in Egypt have tried to anticipate and resolve resistance through a variety of approaches that emphasize open and ongoing communication and broad stakeholder involvement in both the planning and implementation of reform activities. Those approaches are enumerated below. Many of them will be refined and/or repeated as the implementation process continues.

Beginning in the early phases of the pilot project, PHR and the MOHP Technical Support Office (TSO) worked together to design and deliver information seminars. Seminars were followed by

invitations to physicians and nurses to submit applications for recruitment for the family health units and centers.

Early outreach to stakeholders also included focus group discussions with physicians to explore attitudes toward existing health system issues and payment policies, as well as possible ways to resolve those issues.

The strategy used to staff the pilot service delivery—selection of individuals with the commitment and the clinical, financial, or administrative skills appropriate to their roles, done through open competition—is essential to the successful implementation of change. Such a selection process can provide an opportunity for major stakeholders to learn, become involved with, and assume ownership of the process.

The use of policy/discussion papers as a tool for policy development is an additional device designed and implemented specifically to foster communication, collaboration, and cooperation among the various stakeholders. The policy development process has been kept informal so that it encourages feedback and invites challenges to the recommended course of action. Measures to increase participation and discussion prior to the presentation of options to the Minister of Health and Population would make the process even more effective.

At the local level, regular meetings with Technical Support Team (TST) and HIO Advisory Committee members have ensured that the individuals responsible for the implementation of the family health units and centers are well informed, fully involved, and well supported.

In mid-September 1999, a participatory workshop to plan the FHF was held using a strategic management approach and tools to focus on the implementation of the FHF. Participants included key stakeholders from the TSO, the central HIO and its Northwest Delta Branch, the TST, the HIO Advisory Committee, the MOHP/Alexandria, the Seuf service delivery pilot site, and PHR.

Output from the meeting included an action plan for establishing the FHF; a working paper summarizing the workshop's conclusions for the Minister of Health and Population; and a detailed description of the responsibilities, training needs, and reporting relationships of the FHF director, the governorate-level Board of Trustees, and the High Committee on Health Insurance (prepared after the workshop).

Workshop participants further expressed a need to better understand the issues related to the financing of the pilot project, and, in particular, the implications on FHF other operations as well as on the service delivery pilot sites. To meet this need, a workshop on financing was held with the same participants in December 1999. A third workshop, planned for late January 2000, will focus on pilot site accreditation and performance contracting strategies.

There are several essential next steps for successful management of the change process as the fund is implemented. These include the need for increased stakeholder participation (and possibly the inclusion of new stakeholders) in analysis and planning based on pilot results, coaching, and support for FHF managers, and the accommodation of changing institutional roles, likely to be felt most deeply in the HIO.

Chapter 3: Institutional Options

Chapter 3 presents three options for placing the FHF institutionally. As background, it describes existing institutional arrangements in the HIO regional office. It provides analysis of the key personnel needed for the pilot effort and the areas of responsibility that the personnel must manage, working under a true fiduciary body; it also outlines the key elements of any fiduciary function that may be assigned to the FHF's board. Importantly, it outlines three distinct options for implementing an FHF structure; alternatively, the options could be viewed as three stages in the establishment of the FHF, with one option followed by regulations and decrees that enable the second option, and then the third.

> Option 1 would keep the FHF function as a disbursement account within the HIO, reporting to the HIO branch director and without a fiduciary body with full powers or administrative autonomy, in particular in the personnel area. Option 1 can be established without a decree or law change.

> Option 2 would be more difficult to enact, probably requiring a ministerial decree, but would place the FHF in a position of greater autonomy. In it, the FHF would report to a fiduciary body with greater independence from the HIO. Its core administrative unit would be staffed independently rather than with staff seconded from the HIO. The HIO would retain some powers, including signatory authority following board review of certain documents.

> Option 3 would make the FHF a Unit of a Special Nature, with full autonomy. The HIO would participate only as a member of the fiduciary board. The FHF would be fully staffed, permanently absorbing some employees from the HIO. Nearly all stakeholders consider Option 3 the ideal approach, but the need for a presidential decree to enact it has been the single greatest negative factor in discussions. In the sequential approach proposed above, this would be the third step in the sequence of making the FHF an autonomous body with its own management, oversight, and financial resources.

In addition, the chapter makes recommendations for action, and identifies and analyzes possible obstacles to the process. Many obstacles have to do with the doubts and anxieties of government officials who lack adequate information about their changing roles, finances, what will be expected of them in this new management culture, as well as the pace at which changes will be implemented.

Chapter 4: Organization Design

The pilot project in Alexandria is implementing, for the first time in Egypt, the concept of a separation of health insurance payer functions from service provider roles. The Alexandria Governorate Family Health Fund, which is assuming the payer and contracting agency functions, will model this separation. Chapter 4 describes the internal organizational structure and operating principles proposed for the FHF.

The organization and operating principles incorporate recommendations made in the June 1999 trip report, principal among them being a clear mandate for the FHF as a quality contracting agency; a description of each FHF structural unit; an organization chart that includes reporting relationships, including the nature of the relationship between the director and the Board of Trustees; and a set of behavioral and accountability principles. Such clarity of roles and relationships is needed to ensure collaboration rather than competition between the director and the management team.

As the project progresses beyond the pilot stage, the FHF will expand its fundholding capacity and the range of services it finances. To that end, operational principles are proposed to govern an organizational structure that must evolve to meet the growing responsibilities. Prominent among those principles are accountability requirements for a thorough and responsive operation, clearly defined authority for those responsible for FHF performance, and a rational alignment of FHF functions.

Key positions are proposed. They include FHF director, the director of the Insurance Operations Division, director of the Strategy and Policy Group, the director of the Monitoring and Evaluation Group, and director of the Support Services Division.

Responsibility for the administration of performance contracts and payment of incentives will reside in the Insurance Operations Division, more specifically in its Provider Payment Department. As the pilot project progresses, the department will assume responsibility for working closely with the pilot service delivery site teams to supporting continuing improvement of their performance; this will include explaining the implications of the regular performance reports received from FHF and providing processes for effective use of the information.

The Strategy and Policy Group is responsible for recommending to the FHF director new performance contracting indicators as part of an overall strategy to sustain and gradually improve the quality of primary health care services over time. The Monitoring and Evaluation Group will be responsible for ensuring that pilot service provider sites are correctly collecting and submitting performance indicator data using the encounter form mechanism. The Support Services Division will include the Management and Information System (MIS) Department. (The functions of each unit are illustrated in figures in the body of the report.)

Linkages between the Family Health Fund and the other organizational components of the pilot project will occur primarily through the FHF's performance contracting and provider payment operations, fully supported by MIS data collection, tracking, and reporting functions.

Chapter 5: Incentives for Improving Care

The Family Health Fund, as a quality contracting agency, must set quality standards and develop and enforce mechanisms that monitor and ensure high-quality performance by those who contract with the FHF to provide health care services. Incentive-based payments will be a chief mechanism by which the FHF will enforce its standards, although other, non-financial mechanisms may also be offered. The FHF will use research by PHR and others to identify the quality, efficiency, and access problems currently existing in the health care delivery system, and to develop mechanisms that will provide financial and non-financial incentives to providers to improve the care they offer.

Categories of criteria have been identified for performance-based contracting, all to enhance the quality of care. They are: (1) productivity-related indicators (numbers of patients seen), (2) customer service indicators (levels of satisfaction), (3) quality indicators for vertical programs, (4) drug volume/cost indicators, (5) referral volume indicators, (6) indicators for health outcomes for rostered patients, and (7) indicators for maintaining facility accreditation.

Chapter 6: Management Information Systems

Chapter 6 discusses the importance of the information system in administering performance-based contracting methodology. Data collection is critical to performance-based contracting. The process must be transparent, objective, technically sound, and organized to support analysis of the FHF's financial component. The financial system, and incentives in particular, depend on the types and accuracy of data collected primarily through the encounter form. Proper flows of information emanating from encounter form results are the basis for setting up and maintaining the basics of the MIS.

The Family Health Fund MIS is to become the basis for data collection, information and statistical systems, and contract administration for FHF operations. The MIS will support a great number of activities, among them performance-based contracting, accreditation, budgetary planning and control, advice to the policy-making level, and data quality monitoring.

In doing so, the MIS will support a great number of functions: identification of beneficiaries, identification of providers, cost analysis, actuarial analysis, feedback on services provided to contracted facilities, and patient encounter quality. The FHF-MIS will contribute to the High Committee on Health Insurance's ability to make primary health care policy and to follow up with related areas of reform.

MIS implementation issues center around the interfacing of manual and automated systems until such time as all the key system are automated. Training in the mechanical elements of data collection, analysis, and flow are critical.

Chapter 7: Communications and Marketing

Communications and marketing are critical to the establishment and launch of the Family Health Fund, as they have been to the entire health reform program in Egypt.

Communications and marketing activities for the FHF are divided into two phases: (1) diverse policy communications activities to foster consensus-building and understanding of proposed policies for the establishment of the FHF; and (2) after the FHF is established, continued policy communications to enhance understanding of the FHF's role and objectives, and marketing activities to promote provider and patient participation in the FHF. While each activity targets a specific audience and purpose, some activities are applicable to both phases:

> Consensus-building and policy decision making (Phases 1 and 2)

> Awareness and capacity-building (Phases 1 and 2)

> Marketing and public relations (Phase 2)

> Health promotion (Phase 2)

> Public information (Phase 2)

are:

Family medicine: Promoting the practice of family medicine among providers; promoting
nurse team among the population.

Public/private contracting and provider incentives: Promoting provider methods that
-effective primary and preventive care;
ice and participation in the FHF.

Quality and accreditation: Promoting awareness of the quality improvement and

acceptance of accreditation standards among providers and awareness among patients of

role not only as a financing entity but also as a guarantor of sustainable, quality services.

Social insurance: Promoting the FHF and r -
effective, quality care; protecting the poor

> –patient
respect; promoting the concept of provider/facility competition for pa
good quality of care.

consensus for proposed policy reforms, and promoted decision making by presenting options based on research. Activities and p -building workshops,

presentations to top decision makers and key stakeholders at the central level of the MOHP and in the

relations are exclusively handled by the Minister of Health and Population.

ers to contract with the FHF and patients to enroll in the FHF. To avoid losing customers (both providers and patients)

tasks:

The FHF should elaborate the FHF

> The FHF should set patient fee schedules and exemption policies.

The quality improvement directorate should determine the accreditation status of

> The FHF should designate a spokesperson.

The TST should designate a marketing counterpart until the FHF recruits a qualified

Policy communications to support the start up of the FHF should continue, focusing on financing and contracting. The family medicine appro
marketed. At start- *not* warranted. Appropriate marketing activities

include: word of mouth, presentations at mosques and community centers, simple flyers, FHF brochures, a "Family Health Day," and community billboards. When the service delivery sites and the FHF expand, mass media like radio and television can be added to promote the FHF.

It is critical to inform rostered patients at pilot service delivery sites about the proposed FHF roster and other fees to minimize negative political fallout that could risk the launch of the FHF. A graphic identity must be fashioned for the new FHF including a logo that is associated with "quality

s need to be factored into an FHF or TSO/TST budget.

Chapter 8: Policy Planning and Development

Chapter 8 uses a conceptual framework for a policy process to discuss issues and approaches related to strategic policy planning and development for the FHF as it evolves to become the financing agency within a full-functioning health insurance system. Overall direction for the 10- to 15-year Egypt Health Sector Reform Program was determined by the decision of the Minister of Health and Population to emphasize the development of a strong mechanism for primary health care. The setting of policy direction for the reform was the catalyst for support of donors financially and with expert assistance given to the task of formulating and implementing the technical content of the reform policy.

Stage 1 of the policy process focuses on policy formulation and legitimization. To specify the technical content of policies necessary for the longer-term development of the FHF as a full health insurance fundholding organization, technical analyses need to be complemented by expanded stakeholder participation. Stakeholder participation also contributes to legitimacy.

Stage 2 in the policy process is constituency building. It is directed at building understanding and support among groups and individuals who will be affected by and can influence the implementation of the reform. Active and informed community participation is essential to the effective functioning of the pilot model and the FHF.

Resource mobilization is stage 3 of the policy process. One of the greatest resource challenges will be funding for the current and future operations of the FHF and the health care system as a whole. This will become particularly critical if/when the MOHP and HIO change their roles from health insurers, financing agencies, and health care providers to service providers only.

Stage 4 in the policy process is implementation design and organizational restructuring. The prime example of this is establishing the FHF. It will create an organizational culture that explicitly links performance to reward and recognition both inside and outside its organizational boundaries. Another example of a new arrangement essential to the essential functioning of the pilot project is the fiduciary Board of Trustees.

Progress/Impact monitoring is stage 5 in the policy process. The High Committee for Health Insurance, with input from the fiduciary Board of Trustees and the FHF management team, will play a key role in using lessons learned from the pilot project to determine strategic policy directions. Reports produced by the FHF-MIS will provide essential data for learning and improvement to the service delivery pilot sites, the FHF management team, the fiduciary Board of Trustees and the High Committee for Health Insurance.

Chapter 9: Conclusions and Next Steps

The report closes by summarizing some of the most salient features envisioned for an effective Family Health Fund. It sets out a timeline for operationalizing the pilot FHF in the Alexandria e first half of 2000. Full implementation will yield costing and utilization data. Cost analyses will reveal accurate costs of providing family health services and enable comparisons ll allow for planning the future of the pilot model, both in terms of expanding coverage to more beneficiaries and expanding —in other words, expanding access to care, the original goal of health care reform.

Once this accelerated implementation has been realized, the pilot FHF should be evaluated to

adaptability to other Egyptian governorates. The evaluation should also provide valuable lessons

1. Background

The Health Sector Reform Program is a 10- to 15-year reform process initiated by the government of Egypt (GOE) with the assistance of a number of donor agencies, which include the following:

> United States Agency for International Development (USAID) ($60 million over the first four years of the reform period)

> The World Bank (loan of $90 million)

> The European Union ($120 million)

> The African Development Bank ($13–14 million)

In addition, the GOE will contribute $100 million as its local share.

At the outset of the reform program, in the mid-1990s, the Minister of Health and Population, His Excellency Dr. Ismail Sallam, selected as its strategy the development of a strong mechanism for primary health care (see Berman et al., August 1997). Early in the process, USAID made the focus of its contribution the reform effort a health policy support project (HPSP). HPSP has two objectives: (1) to feasibility-test in a pilot district a care model and finance model for an effective system for family health care and (2) to support regulatory change integral to such a system. The bulk of the USAID contribution ($40 million) was to be in the form of tranche payments to the GOE upon the achievement of certain agreed upon annual benchmarks, with the balance ($20 million) to be spent on technical support to assist in the achievement of the benchmarks.

A number of options were presented to the Minister for the location of the pilot project, based on an analysis of the population demographics and resources available in the various governorates. The Minister selected the Governorate of Alexandria as the location of the initial pilot project; lessons learned in Alexandria would be used for expansion of the model to two other governorates, Sohag and Menoufia. It was agreed that, to be effective, the pilot project would be restricted to service delivery sites in the Alexandria district of Montazah, and that the pilot sites would include facilities belonging to four provider sectors: the Ministry of Health and Population (MOHP), the Health Insurance Organization (HIO), the private sector, and the non-governmental organization (NGO) sector.

The Alexandria pilot project has three essential components, *all of which* must function together to ensure high quality and sustainability of the family health model:

Care: pilot service delivery sites that are designed to deliver high-quality health care to beneficiaries

Financing: a Family Health Fund (FHF) as the *quality contracting agency* that will pay performance-based incentives to providers at the pilot service delivery sites to ensure that high quality services are consistently provided

Regulation: project, for accreditation of facilities, and for execution of contracts between the FHF and accredited facilities.

The demonstration project has come to be known as
The following section enumerates some of the fe

1.1 Components of the Family Health Care Model

Service Delivery Sites

The family health care project requires that each of its service delivery sites:

Have renovated facilities

> ave been selected by a structured competitive process

>

> Ensure that necessary training is provided to staff to enable them to maximize their effectiveness

> king hours that allow convenient patient access to family health services and 24 hour a-

> Use improved patient flow mechanisms to minimize waiting times

Use a new system of medical records to keep individual records within a family fol

> Allow for a family doctor and nurse to work together as a family practice (FP) team

Ensure that the FP teams work in two shifts to cover the working day

> "Roster" (register) patients with a specific FP team for continuity of care

Give each FP team re

> Provide two FP teams (morning and afternoon shifts) with one family practice examining room

> nt access to services during the two shifts

>

> Collect user fees and use such fees to meet the operational needs of the service delivery site

Collect co payments for drugs and use such fees to ensure availability of necessary drugs

- Collect roster fees (membership fees) from patients who roster in the pilot project and send such roster fees to the FHF

- Use the patient encounter form for each patient visit and send accurate encounter data to the FHF

1.1.2 The Family Health Fund (Quality Contracting Agency)

The establishment of the Family Health Fund as the "financing entity" is a policy goal supported by USAID and a specific benchmark for completion in 1999. On December 29, the Minister of Health and Population approved the establishment of the FHF by issuing a decree to authorize its organization and operation (see Annex A). The decree will allow the FHF to administer contracting strategies to ensure that the pilot sites continue to provide high-quality care to patients. More specifically, the contracting strategies are that the FHF:

- Contracts only with accredited facilities

- Receives roster fees from service delivery sites

- Receives data on patient encounters for each visit in the specified format

- Devises and administers contracts with service providers, to meet clearly specified quality standards for performance

- Develops an incentive payment mechanism to reward staff at the contracted pilot service delivery pilot sites for meeting performance standards

- Devises management information systems (MIS) to collect and track data for monitoring of service delivery sites

- Uses MIS for automated process of contracting strategies and incentive payments

- Ensures that data used for contracts are accurate

- Issues monthly reports to service delivery pilot sites on achievement of performance indicators

- Issues statistical data on patient encounters to the National Information Center for Health and Population (NICHP) and HIO

- Works with sector programs to determine ways to provide them with necessary data for sustainability of their programs

- Monitors efficiency and effectiveness factors in the service delivery sites, publishing comparative data monthly

- Negotiates special rates on behalf of FHF beneficiaries for referred care outside the basic benefits package

Regulatory and Information Requirements

The traditional role of the Ministry of Health and Population has been as a provider of health care facilities and services to ensure access by the more di
In contrast, the pilot project for family health care envisions the MOHP as a regulatory body that facilitates the smooth functioning of the various components of the health care system. More will:

Approve the necessary financing mechanisms for the pilot project

>

> Apply a formal process for accreditation of facilities, administered by the Quality Improvement (QI) Directorate of the MOHP

> ary decrees to allow accredited service delivery sites to contract with the FHF

Devise regulations to meet the operational requirements of the FHF as well as the service

> Participate in the evaluation of the pilot project to determine lessons for broader rollout

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1.2

The initial phase of the pilot project emphasized setting up the service delivery sites. Significant refine mechanisms for:

>

> Training of doctors and nurses

Patient flow systems

>

> Reception of patients, collection and use of user fees

Systems for drugs supply and disbursement

>

> Collection of data using the encounter form

>

The success at Seuf paved the way for subsequent MOHP family health unit openings at way to recruit at least one private sector service delivery site and one NGO site for the pilot project.

The Seuf experience also provided important operational and encounter data on which to base the continuation and expansion of the pilot project. Some of the key findings from encounter data at Seuf are:

- The MOHP has attracted those most in need and least likely to have health insurance.
- Women are usually uninsured (86.9 percent of females are not insured; in contrast, 64.8 percent of males are not insured).
- Ninety percent of the visits are by infants, school age children, women, and the elderly.
- Patient satisfaction surveys indicate a high level of support for the integrated model of care as well as a high level of loyalty to the FP team.
- Families appear to be willing to pay for high quality care.
- Social workers grant fee exemptions to less than 10 percent of the cases.
- Between opening day in May and July 1999, enrollment of rostered patients grew to 4275 families (19,971 individuals), in response to which two extra FP teams were added.
- Only 3.4 percent of visits to family doctors result in a referral.

It is important to note that the establishment of pilot sites *per se* will not ensure that high quality is maintained or that the project will be sustainable. The emphasis must shift to the second vital component of the pilot project, which is the establishment of the Family Health Fund.

1.3 Foundations of the Family Health Fund

The report entitled *The Egypt Health Sector Reform Program* (Afifi, El-Saharty, Schieber et al., December 1997, also known as "The D4 Report" after the four main donors that contributed to the development of the report) contained the following statement (p.41):

> Health sector reform is bound to involve changes in traditional roles assumed by major health sector players. The capability of those institutions to effectively assume their reformed roles is requisite to the feasibility, the successful implementation and the sustainability of any reform.
>
> It is therefore important to assess the organizational structures, functioning and culture of institutions and parties which have (or are likely to assume) a role in financing, organizing and providing health services and/or proposing, analyzing or evaluating health policies under the prospective sectoral reform. Both the *organizational strengths* and constraints in relation to institutional structures, functions and cultures will be tackled, together with an identification of the required *organizational changes.*

Building on these concepts articulated early in the discussion of reform, the design of the pilot project details FHF organization in order to emphasize operational capabilities needed for quality

-defined roles and responsibiliti
will ensure that the FHF will demonstrate a new concept of organizational effectiveness.

> Recommendations for Family Health Fund organization structure and operational principles

> A study of Family Health Fund organizational infrastructure and relationships was conducted in June 1999 (see Edmond, June 1999).

> cing for the pilot was prepared (see Nandakumar, August 1999).

>
members of the MOHP, HIO, the MOHP's Technical Support Office (TSO), and the Technical Support Team (TST)[1] of the MOHP in Alexandria to address issues concerning establishment of the Family Health Fund (see Scribner and Edmond, September 1999)

> A second workshop was held in December 1999 with the same participants to review financing proposals.

> Discussions were held between PHR and a team of senior TSO members, assisted by the TSO Legal Counsel, to draft a decree for the approval and signature of the Minister of Health and Population. The draft was completed in November 1999, and the Minister signed the decree on December 29 (see Annex A).

[1] The TSO and TST are part of the MOHP.

2. The Change Process Leading to Establishment of the Family Health Fund

The scope of reform that the Egyptian health care sector has begun implies complex and extensive change. Change is a process, not an event, in which certain dynamics are inherent and predictable. One of these dynamics is resistance to change by persons with vested interests in the tradition system, who wish to decelerate the process of change in order to preserve their control. Resistance at its most extreme can take the form of denial, deliberate confusion or misunderstanding, unwillingness to participate, and even attempts at sabotage. Fortunately, resistance to change is predictable and strategies for managing it and limiting its negative impacts can be developed. Strategies used extensively by health sector reformers in Egypt are open and ongoing communication and broad stakeholder involvement in the planning and implementation of reform. Various approaches to achieve open communication and stakeholder involvement—informational seminars, focus group discussions, competitive hiring processes, participatory work planning, and others—have secured broad support for the Family Health Fund concept and initial implementation, and their use will continue through full implementation. These approaches are described below with suggestions for improving their effectiveness.

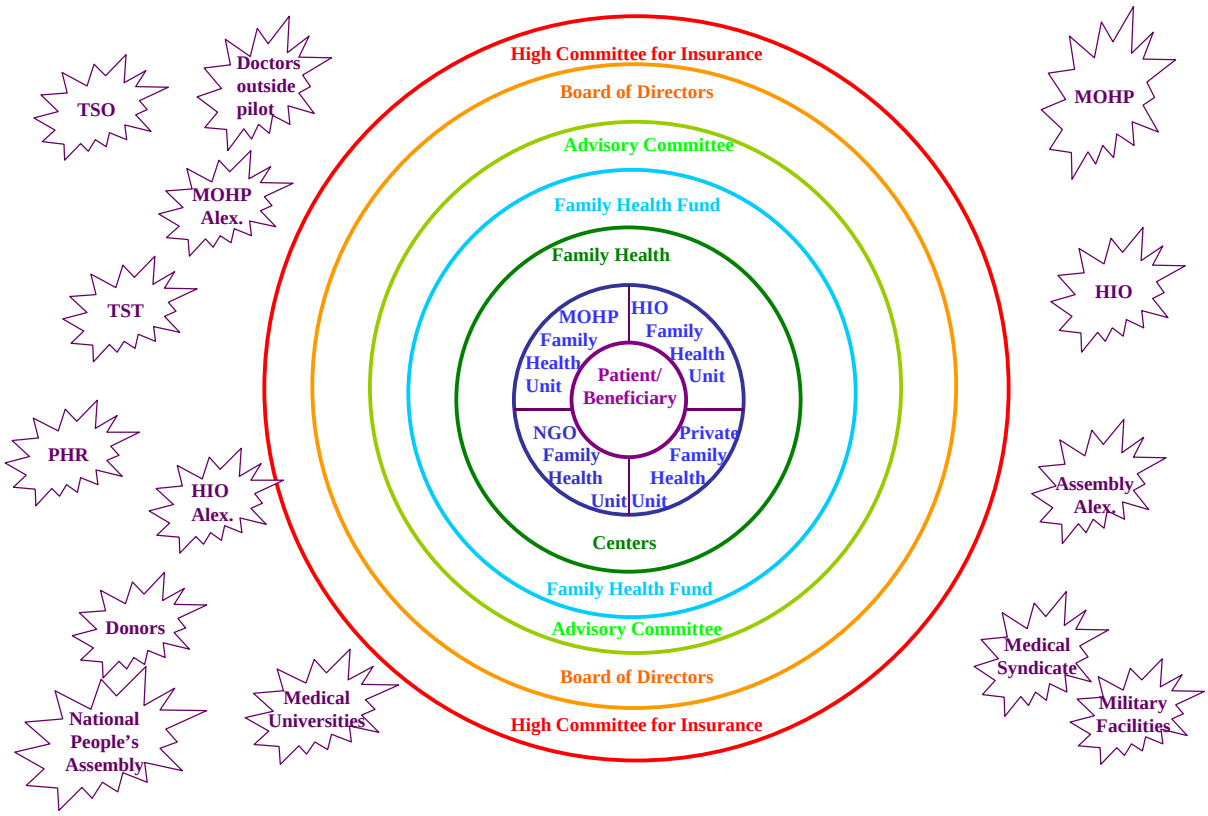
For example, Figure 1, The Pilot Project System, was first introduced during a September 1999 participatory work planning meeting to help key stakeholders visualize all the essential components of the Alexandria pilot project. The figure contains concentric circles, which represent the various components of the project and which radiate from the patient/beneficiary at the center—so placed to remind stakeholders and others involved in the project that *the only reason for development of service delivery sites and the FHF is improved access the high quality primary health care services for patients/beneficiaries of the pilot project.*

2.1 Information Seminars and Consensus Building

Placed around the circles of Figure 1 are the major stakeholders with an interest in the development and impact of the family health project in general and the Family Health Fund in particular. Some of these stakeholders—the Ministry of Health and Population, Health Insurance Organization, Technical Support Office, Technical Support Team, HIO/Alexandria, and MOHP/Alexandria—also play an essential change agent role in the pilot project and are therefore particularly significant. Their immediate and significant involvement was a crucial step in order to increase understanding about, develop feelings of commitment to and ownership of, and reduce or eliminate resistance to the FHF.

Beginning in the early phases of the pilot project, PHR and TSO staff worked together to design and deliver information seminars to key stakeholders. The purpose of these seminars was to explain the role of the Alexandria pilot project for primary health care within the broader and longer-term Egypt health sector reform. They also served to describe the development of the FHF, the family health units, and the referral sites as the essential components of the pilot project and to promote the policy dialogue in general terms.

Figure 1. The Pilot Project System



Seminar audiences included members of the TSO, the TST, and the HIO Advisory Committee, as well as physicians and nurses from the MOHP, HIO, and the private/NGO sectors. Following the seminars participating physicians and nurses were invited to submit applications for employment at pilot family health units and centers.

These information seminars were effective in introducing the pilot project to key stakeholders. One suggestion for making future seminars even more effective is to design and implement a follow-up mechanism. For example, attendees could be sent a summary of seminar proceedings, in Arabic, within several days after the seminar. Future seminars could also solicit from participants their hopes, concerns, and other ideas related to the seminar topic; this might identify in advance potential resistance to as well as possible support of the reform.

2.2 Focus Group Discussions

Early involvement of stakeholders also included focus group discussions with physicians to explore attitudes toward current health system issues and payment policies and possible scenarios for the future.

Focus groups can provide both an excellent opportunity for stakeholders without formal authority in the reform process to become actively involved in its implementation, and valuable first-hand data for specific aspects of the reform unavailable through any other means. In the first phase of the pilot project, focus group participants were nominated by a significant stakeholder in the process.

Future focus group activity will be more tightly structured to ensure a broader representation of randomly selected participants, more precisely worded questions aimed at achieving the desired objectives, and more control of the flow of discussions.

Chapter 7 on Marketing/ Communications provides more detail on focus groups.

2.3 Structured Staff Selection Process

The staffing process currently used in the Egyptian health system relies on appointments to positions without the benefit of open competition to encourage selection of the best qualified candidate.

The strategy used to staff pilot service delivery sites is based on the belief that selection of employees with the necessary technical skills as well as commitment to their roles in the process, is essential to the successful implementation of change. In addition, it recognizes that the selection process can provide an opportunity for major stakeholders to learn, become involved with, and assume ownership for the process.

The structured staff selection process was first used to hire the physician/nurse teams to operate the family health units. They were chosen based on their understanding of family practice, knowledge of reform, and attitudes that matched the focus of the project on preventive medicine and concern for patient satisfaction.

The steps in the process included:

> Advertising the position

> Choosing a hiring team

> Preparing for the interview

> Conducting the interview

> Conducting the assessment

It has been recommended that this same structured staff selection process be used to involve major stakeholders and ensure that the FHF is staffed and operated by the best qualified individuals.

2.4 Policy/Discussion Papers

The ongoing use of policy/discussion papers as a tool for policy development is an additional device designed and implemented specifically to foster communication, collaboration, and cooperation among the various stakeholders to the reform process. It also serves to build consensus; isolate issues to reduce complexity, contradictions, and confusion; enable prioritization of major steps requiring decisions; and provide an audit trail of steps taken in the decision making process.

The policy/discussion papers developed to support the change process leading to the establishment of the Family Health Fund contain the following essential elements:

- A definition of the problem or issue
- A background, explaining why the issue is being considered
- A discussion, which includes an analytical assessment of the dimensions of the issue, including its severity, impact, and complexity
- Possible solutions, formulated as options
- A recommendation of the decision required, usually a selection of the preferred option

The policy development process has been kept informal so that it encourages feedback and invites challenges to the recommended course of action via a thorough airing of different viewpoints. It begins with a draft of the policy/discussion paper that is circulated internally within PHR to obtain the comments of consultants and the Chief of Party. Revisions and additions are made to reflect comments received. The paper is then explained to and discussed with senior members of the TSO and their input is solicited prior to publication and broader circulation. Further activities in the design and implementation stages of the reform proceed according to the decision/direction received from the Minister of Health and Population.

Several small changes to the policy development process would serve to make it even more effective than it has been. These include broader circulation of the policy/discussion papers to key stakeholders, followed by face-to-face meetings initiated by the developer of the papers, in which the process is explained, the specific content presented and discussed, and input encouraged. In addition, an explicit explanation to the Minister of the purpose and stages of the process and the significance of his involvement in it, would help to improve its efficiency. Finally, a process needs to be developed for the TSO director to ensure discussion of each policy/discussion paper with the Minister to obtain his decision.

2.5 Regular Meetings with TST and the HIO Advisory Committee

At the local level, regular meetings with TST and the HIO Advisory Committee members ensured that those individuals responsible for the implementation of the family health units and centers are well informed, fully involved, and well supported. As the project moves toward implementation of the Family Health Fund, these same individuals must continue to be intimately involved in discussions about the purpose of the FHF, its major functions, its role in the pilot project system, and its relationships with the service delivery pilot sites. They must also be involved in key implementation steps, including necessary submissions to the Minister and identification and resolution of major implementation issues/concerns.

2.6 Participatory FHF Work Planning Meeting

In mid-September 1999, a participatory meeting was held using a strategic management approach and tools to focus on the implementation of the FHF. Participants included key stakeholders from the TSO, central HIO, TST, HIO Advisory Committee, MOHP/Alexandria, Seuf service delivery pilot site, HIO/North West Delta Branch, and PHR.

Objectives of the meeting were:

> To ensure that all participants fully understand the FHF and its central role in the Alexandria family health pilot project and Egypt's health sector reform, and

> To begin to develop action steps to move forward with establishing the FHF.

Outputs from the meeting included:

> The purpose and activities of the performance-based FHF contracting function

> A synthesis of strengths and weaknesses, opportunities and threats, facing FHF establishment

> An action plan to establish the FHF

> A working paper summarizing the workshop's conclusions, to be presented to the Minister of Health and Population

> A detailed description of the responsibilities, training needs, and reporting relationships of the FHF director, governorate-level boards of trustees, and High Committee on Health Insurance, prepared after the workshop

In addition to these concrete outputs, the meeting provided a significant opportunity for discussion and dialogue among participants from two different and sometimes competing institutions, the MOHP and HIO, whose cooperation and understanding is essential to the establishment and successful operation of the FHF. The meeting also revealed high levels of stakeholder agreement about the preferred options for institutional placement of the FHF and the vision for its role within the pilot project.

Several lessons were learned for planning and stakeholder meetings in the future:

> The opportunity to hear presentations, analyze, and discuss details of significance greatly increases levels of understanding, acceptance, and ownership for the planned changes

> Facilitators would benefit by meeting with participants beforehand to gain a better understanding of the variety of viewpoints on the significant issues

> Co-facilitation with a senior local counterpart would contribute greatly to effective participant involvement

> A longer-term, broader strategic perspective is difficult for many participants and therefore requires continuing emphasis and time for discussion

See Scribner and Edmond (September 1999) for details of this planning activity.

At the September workshop, participants expressed a need to understand the issues related to the financing of the pilot project, and, in particular, their implications on the operations of the FHF as well as on the service delivery pilot sites. To meet this need, a workshop focused on the options for financing the pilot project was held in December 1999 with the same participants. A third workshop,

on the role of pilot site accreditation and performance-based contracting, will be held at the end of January 2000 as a pre-requisite for contracts with the Family Health Fund.

2.7 Expanded Process in the Future

There are several essential next steps for successful management of the change process as the Family Health Fund is implemented. It is inevitable that, as information is more widely circulated and more people feel and see visible evidence that things are changing, the stakeholder base to the reform process will expand. New stakeholders or staff involved in planning or implementation need to be given basic background information and one-on-one coaching prior to their involvement in specific details. This takes time and effort away from the implementation itself, but it is time and effort well spent in order to avoid the spread of incorrect information, inadvertent sabotage, and the risk of alienation. Orientation activities must be planned and responsibility for them assigned in the same manner as other action steps necessary to the successful implementation of change.

The new managers of the Family Health Fund must receive immediate and ongoing coaching to ensure understanding, commitment, and development of feelings of ownership for the Fund and its role in the pilot project. The FHF cannot function effectively otherwise. In addition, the family practice teams at the service delivery pilot sites will need considerable support to fully understand the relationship between their performance, the reports issued to them by the FHF, and the incentive payments to which they will have access. Without successful development of an open and supportive relationship between the FHF and the pilot sites, resistance will be strong and widespread.

It can be expected that once the FHF is implemented, the HIO could face the challenge of a changing role. It is essential that a strategic plan be developed for the future of the Family Health Fund and the nature of its relationship with HIO. This will require decisions from the Minister of Health and Population concerning organizational mandate, roles and responsibilities, and legislative authority.

As the European Union becomes involved in the health sector reform in late 1999, there is an opportunity for PHR to share learning about successful change management activities, so that the pilot projects in Sohag and Menoufia begin with a good foundation for understanding and commitment among their change agents and stakeholders.

3. Family Health Fund Institutional Options

3.1 Objectives of the Study of Institutional Options

In the summer of 1999, PHR conducted a study of institutional options for creating the Family Health Fund. This was at a time when only the service delivery portion of the pilot project in Alexandria was underway. The study had two main objectives:

> Facilitate the process of developing the FHF by determining the relationships and linkages that must be created among the FHF, the MOHP, and the HIO. The FHF organization to be modeled must have the proper degree of administrative independence to take on a role primarily as contracting entity for the service delivery sites, to be established initially in Alexandria governorate.

> Examine ways to compensate and otherwise provide incentives to the future staff of the FHF, and to maintain compensation equity with the existing staff of related agencies. The FHF, by whatever design it takes, will have a special place in the health reform effort, and by its nature will require innovative techniques and the adoption of a new administrative culture. Therefore, there is a great need for adopting FHF compensation policies that will allow the utmost in flexibility and the creation of internal salary incentives to carry on this special work effectively.

3.2 Main Issues to Be Addressed

The recommended options or sequenced steps for the creation of an FHF had to accommodate the following needs and objectives expressed by the MOHP:

> Avoid creating another large bureaucracy within one of the Ministry's agencies.

> Give the FHF a degree of administrative freedom or flexibility while at the same time having all the features of an accountable mechanism for managing critical services and a large amount of funding.

> Make the best use of existing contracting expertise and established procedures to be found in the contracting units of HIO regional branch offices.

> Find a consistent way of making a transition from the traditional contracting function to performance-based contracting.

> Establish a true fiduciary body to perform a financial oversight function for the FHF as it starts to take on contracting responsibilities with the service delivery sites.

> Establish the requirements for an FHF director with the proper financial and contracting abilities and training to operate well under the direction of a fiduciary board.

> Devise internal consistency for the system and find a way to keep control of this new approach through the HIO for a trial period.

> Run the pilot program with a properly specified core staff, with the ability to expand to build up the full FHF organization as coverage approached universality within the governorate.

> Develop transparency, accountability, and public information systems that will build the credibility of the FHF, leading to consumer confidence in it as co-payments and other user financial participation become necessary over time.

PHR prepared a trip report (see Edmond, June 1999) that presented three options that addressed these needs, each representing a different level of FHF dissociation from the HIO, and each requiring a different level of enabling action (i.e., approval, vetting, and legal changes). The following subsections summarize:

> Assumptions for the design of the FHF regarding institutional affiliation, staff compensation, and the contracting function which relate to all three design options

> The three design options

> The fiduciary role of the oversight board

> Implementation issues

> The recommended strategy discussed with the MOHP and other stakeholders

3.3 Assumptions for FHF Design

The administrative activities envisioned under the FHF will differ substantially enough from the traditional contracting activities of the HIO to justify the creation of a new administrative unit, governed by a Board of Trustees.

3.3.1 General Assumptions

Fiduciary responsibility for the FHF should be vested in a Board of Trustees that broadly represents the government of Egypt at the governorate level and also has stakeholder groups represented as full members. This role can be filled by an entirely new entity or by the existing Governorate Coordination Committee.

As the FHF will be a creation of the Minister of Health and Population, it should have freedom and flexibility to perform its role within the scope of reform objectives, yet must have linkages to the HIO in order to benefit from HIO resources and expertise where needed. The FHF should be able to impart new techniques and principles of performance-based contracting back into the HIO. At the policy and overall administrative control level, namely the fiduciary body, the HIO should have a prominent role in assuring that performance-based contracting takes root in the FHF.

The FHF, when established as an account, will have funding sources from outside the traditional ones that support HIO budgets. As such, it will not support the HIO with any surpluses, and

presumably will not receive any subsidies from existing HIO revenue sources to cover deficits. The administrative culture of the FHF should be developed as one of financial independence from the bureaucracy, with the option of evolving FHF into a true "Fund" or a Unit of a Special Nature sometime in the next several years if deemed appropriate. Such revised status would evolve the FHF into a mature organization with little need for linkage to the HIO.

The FHF should be created in its pilot phase with a minimum of legal steps and with a well reasoned and vetted plan and structure. Such a plan and skeleton structure would serve as a basis for rolling out the FHF after its pilot phase.

The FHF must in all respects be consistent with national health reform policies and should be aided by, and serve as a learning experience for, the TSO and TST.

3.3.2 Leverage Existing HIO Resources

To the extent possible, the expertise of the HIO contracting offices should be used to staff the new FHF contracting unit and assist it in becoming viable and effective. The ability of the HIO to contribute staff to it should not impair the HIO in carrying out its traditional duties, since the initial scope and volume of contracting activities of the FHF will be moderate.

The North West Delta Branch of the HIO provides a variety of health services, primarily through small units, all of which report directly or indirectly, vertically to the regional branch director. For the purpose of this analysis, the branch director has two positions reporting directly to him which deal with the major issues and processes regarding contracting. These positions are the deputy director for Technical Affairs and the deputy director for Financial and Administrative Affairs.

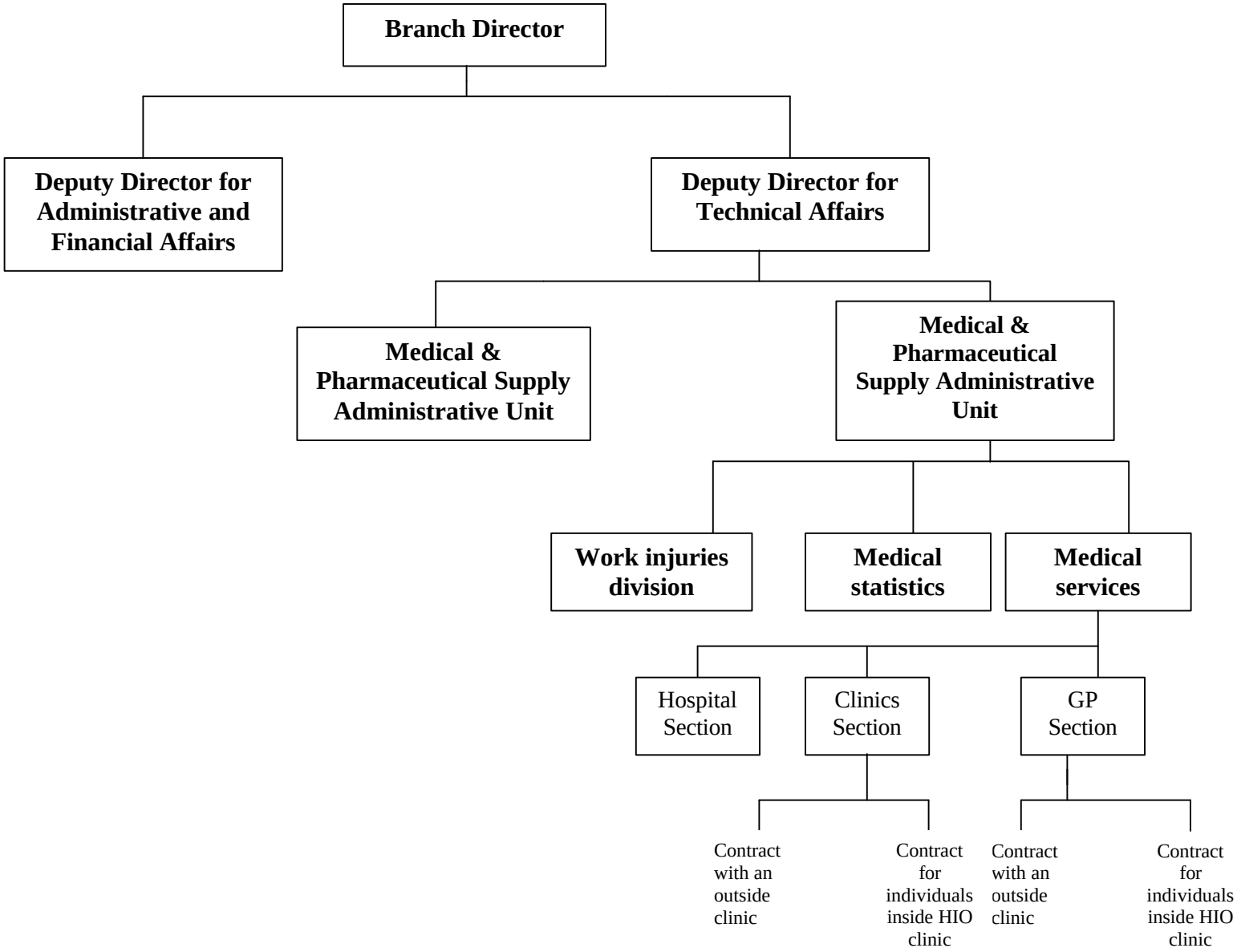
In addition, there are several unit directors who report directly to the branch director involved in quality control and monitoring, including client services. Figure 2 shows in descending order the major administrative units, divisions, sections, and functions of central importance to the contracting function as currently organized.

For more detail on the organization and operations of the existing HIO North West Delta Branch, see Edmond, June 1999.

3.3.3 FHF Staffing and Compensation

The personnel function of the FHF will allow its managers to staff it through any combination of seconding, new hires, and contracting for personnel services as needed. FHF personnel should enjoy a pay for performance system which provides financial incentives at least equal to, and perhaps much greater than, those currently provided to HIO employees by law. In addition, the FHF should be able to contract with outside experts or HIO personnel on leave with incentives that far exceed those currently available to the HIO, should circumstances dictate such a need.

Figure 2. HIO Staffing



Due to the unique nature of the FHF administration, discussed throughout this report, there is justification for offering bonuses and other incentives to FHF staff, whether contracted, seconded from HIO's other offices, or hired directly from outside. This differential in pay, if carried out in the extreme, could cause some questions of equity between HIO's existing employees and the FHF employees. However, if HIO employees are given a fair chance to compete for the positions, as presumably the internal posting process of HIO guarantees, the differentials offered will serve as an incentive to join the FHF unit, rather than serve as a detriment to high morale within HIO.

After interviewing the HIO North West Delta branch director and his key staff, and after considering the responsibilities of the major positions that would be required to start up the FHF, it was recommended that the compensation for FHF positions be at 100 percent to 120 percent of comparable positions existing now within HIO. Comparability between HIO and FHF positions, for the purpose of the study, was based on responsibilities and complexity of duties, and not on the volume of contracts to be managed.

In that incentives are applied as multiples of base pay under the Egyptian system, increasing the base pay by 20 percent would increase any incentives proportionately. As to staff hired under contract, amounts can be set without limitation under the special laws conferring liberal pay provisions upon the HIO.

3.3.4 FHF Contracting Function

The following are minimum assumptions about the nature of the FHF and its contracting units:

> Service delivery sites will be created and have official status as contracted units.

> Service delivery sites will be accredited through a formal process as a precondition for contracting with the FHF.

> Each service delivery site will have administrative capabilities in the form of a business manager responsible for financial and program effectiveness and diligence, and point of contact to the FHF in all contractual matters.

> FHF accounting systems will be based on standardized financial reporting systems and standardized financial reporting and audit procedures used for all contracted service delivery sites

> An effective set of mechanisms will be established for certifying and making timely payments to contracted units in a way that is consistent with and promotes the set of incentives to be instituted to encourage a high level of provider performance.

> The fiduciary body will have an audit function, either with internal staff or through the assignment of the Ministry's independent auditing staff, with responsibility to report findings.

> The fiduciary body must recognize the use of performance-based quality assurance mechanisms that use data collected from service delivery pilot sites on the FHF encounter form.

> A grievance mechanism for doctors and patients should be established that is independent of the contracting function of FHF. It is critical for the FHF and its board to relate to the contracted units and not be involved in disputes raised by individual doctors. At the same time, it is important for the fiduciary board to be aware of the broad doctor-related issues that develop, as well as the customer service satisfaction levels, from a distance.

> Where there is considerable flexibility in the amounts the Minister may pay contracted staff, it may be necessary to develop detailed policies on incentive pay and the amounts allowable for contracting, in order to lessen pay inequity claims and the potential for abuse some years in the future as the system takes hold all around the country.

3.3.5 The FHF as a New Model for Contracting

The contracting function of the FHF will differ markedly from that currently performed by the HIO in the following respects:

> The consequences of FHF's activities, namely the creation of an entirely new culture of contracting based on the premise that compensation for performance will become a standard practice in the Egyptian health insurance field.

> The leadership that will be required of FHF managers and top staff to "sell" this concept to the public and have it become enculturated into the Egyptian bureaucracy—a reverse learning process for the HIO in particular

> The need for FHF to develop and observe transparency procedures that will by their nature add to the administrative burden of contracting

> The vesting of fiduciary responsibility for the FHF in an outside Board of Trustees or a subcommittee of the Alexandria Governorate Coordination Committee, adding complexity to the duties of the top staff, not the least of which will be a very substantial strategic planning and implementation component that cannot fail to keep pace with market demands and the progress of health care reform in general.

See Chapter 4 of this report and the Sadiq trip report (June 1999) for complete descriptions of the duties of key positions that have tentatively been defined.

3.4 Three Design Options for the FHF

PHR presented three options on the general theme of an FHF with special contracting functions. They vary from the least extensive, requiring only the Minister's approval for implementation, to the most extensive, requiring a presidential decree. These options were presented either as independent design choices to institute the FHF, or as phases in the long-term process of creating the FHF.

Edmond (June 1999) contains more details on the three options, including a detailed risk assessment of each option. Descriptions of each option are summarized below.

3.4.1 Option 1

Option 1 conceptualizes the FHF as an HIO account for disbursement purposes, staffed as an HIO unit reporting directly to the branch director. The fiduciary body would be a Board of Trustees or the Alexandria Governorate Coordination Committee, but only for auditing and general oversight (see Figure 3).

This is the least difficult option to initiate, requiring no decrees or law changes. It leaves the FHF function within the HIO and appoints an FHF coordinator within the North West Delta Branch of the HIO, but sets up a fiduciary board with strong oversight and audit powers. In this model, the FHF is a repository for funds only, and the staff work is carried out primarily by HIO staff assigned to assist the FHF coordinator.

The FHF in its pilot phase will have many of the characteristics of a division-level organization, although with a substantially lower volume of contracting activities. In this option, the FHF would have the status of a division, although its coordinator would report directly to the HIO regional branch director, and not through two other levels as divisions currently do.

Reporting by assigned employees and any contracted staff is through the coordinator to the HIO branch director. The Quality Improvement Directorate of the Ministry must be fully operational to conduct accreditation of service delivery sites and provide to the FHF training and technical assistance in establishing performance standards. Donor-funded staff of the National Technology Laboratory (NTL) also contributes to FHF effectiveness, and, as a result, the FHF develops a cadre of highly skilled personnel to perform the contracting duties.

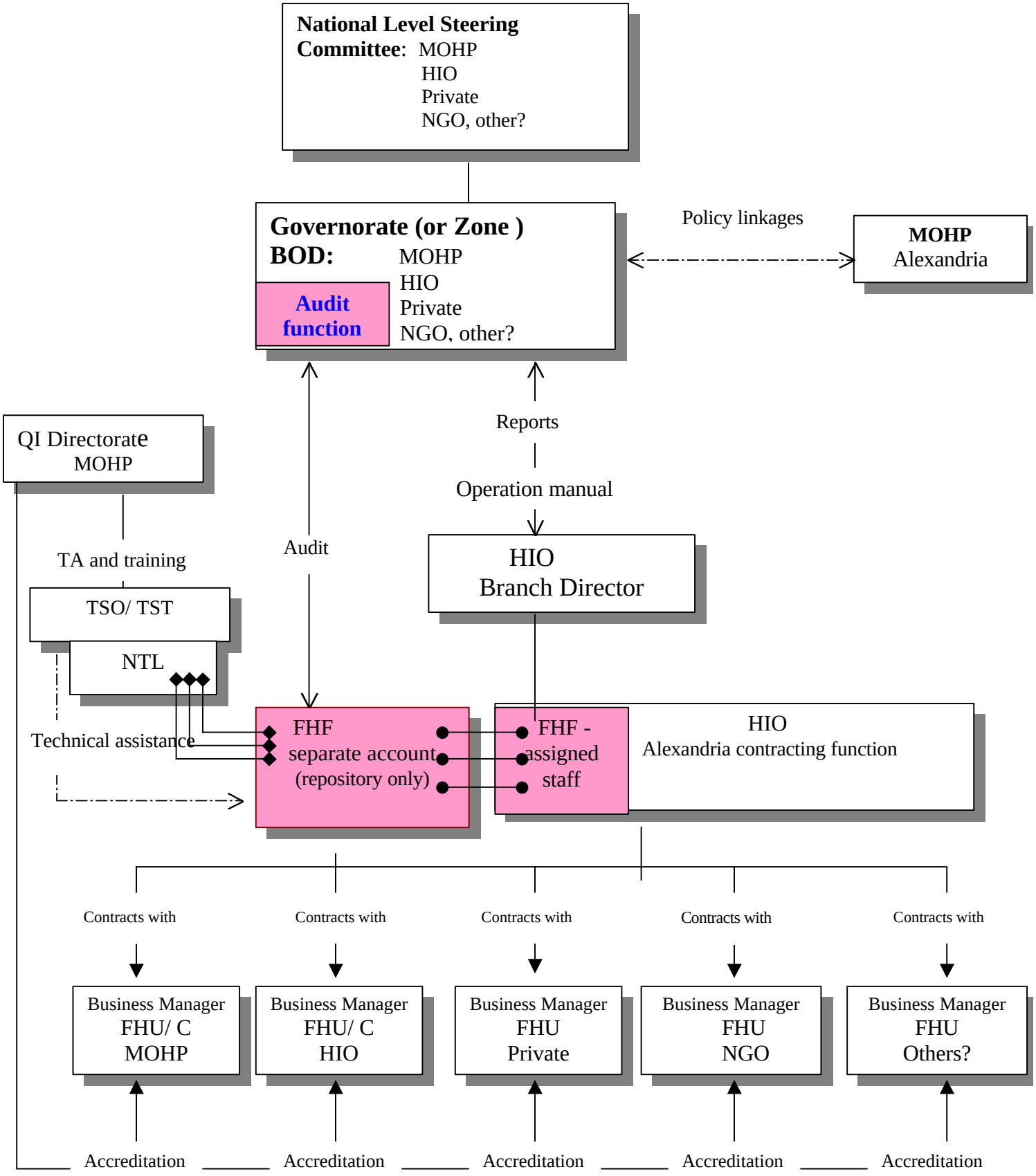
Linkages between the FHF and HIO remain strong, in part through the staff connection, but also through HIO's legal powers to contract, and the technical strength of the very large HIO organization. The HIO branch director has a firm hand in this, on a daily basis. He is responsible for all FHF staff, and maintains a routine relationship with the oversight board, on which he also sits as a full member.

The fiduciary function is performed under the Board of Trustees, and its main responsibility is one of a strong auditing function.

In this model, much depends on the HIO branch director, who has signatory powers over the contracts and payments. The FHF staff might be formed as a unit with the rank of division, and report directly to the branch director without going through HIO's current Medical Affairs department's system of contract compliance checks and inspections. However, the assistance provided by the TSO/TST, the NTL staff, and the QA Directorate to FHF will compensate for the HIO Medical Affairs Department oversight that is removed through implementing this model.

The MOHP maintains policy links through the High Committee for Health Insurance and through its membership on the Board of Trustees at the governorate level.

Figure 3. The Pilot FHF Base Model: Option 1—Requires No Decree



3.4.2 Option 2

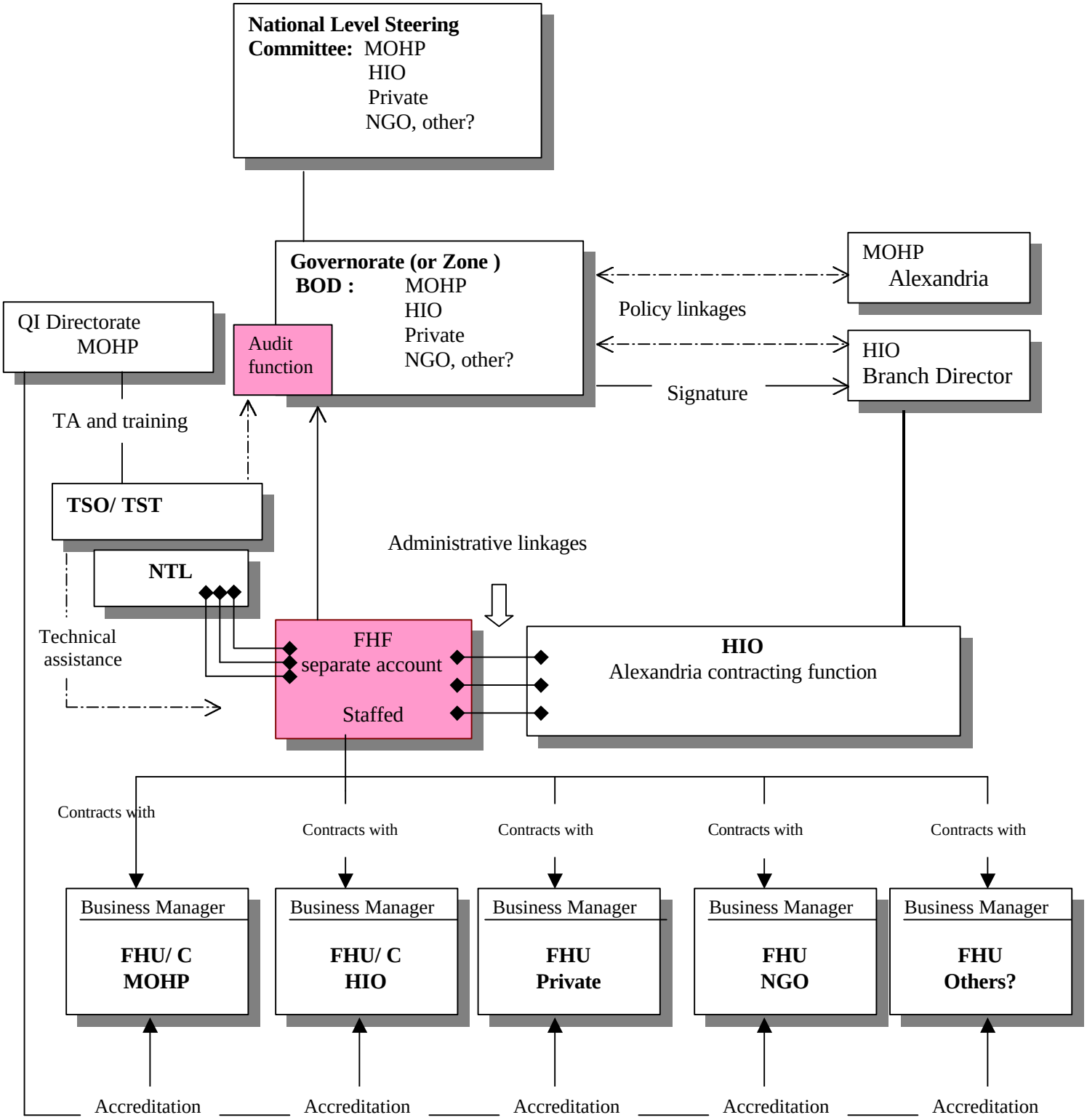
Option 2 presents the FHF as an HIO account, independently staffed, and controlled by a fiduciary board (see Figure 4). A ministerial decree is not required to establish the FHF in this way, but *it is strongly recommended* in order to clarify roles, to deal with the signatory power issue, and to institutionalize all other necessary measures.

As a staffed, separate account, the FHF would solely be responsible for contracting with the service delivery sites, except that the HIO regional branch director would maintain responsibility for signing documents. HIO staff would not be involved in contract review for the FHF.

This model may be seen as the second step towards the institutionalization of the FHF, and, if so, it is presumed that HIO staff will shift over to the FHF in a natural fashion as contracting programs are developed. Much oversight capacity and contracting expertise will therefore be in place.

In a setting with a fiduciary board, it is logical and desirable to enable the board to review and sign documents, especially of a financial nature. Yet the branch director will still need to sign documents, as required by law. In order to accommodate this need, the ministerial decree could enable the board to sign prior to sending documents on to the branch director for final approval. This would have the effect of adding a level of oversight, and the branch director could send documents to selected members of his staff for final review as long as such a process is not repetitive or overly time consuming.

Figure 4. The Pilot FHF Base Model: Option 2—Ministerial Decree Is Preferable But Not Necessary



3.4.3 Option 3

In Option 3, the FHF is a staffed, independent fund and organization with a fiduciary board (see Figure 5). A presidential decree would be required to establish the FHF as such.

This option or stage is the ultimate in FHF design, and would require a presidential decree and some statutory changes (having to do with the HIO's sole authority to deal with insurance matters) to effect. In this arrangement, the FHF is Unit of a Special Nature totally outside the control of the HIO. All other mechanisms are the same as in the other options, including HIO membership on the fiduciary board. All HIO contracting roles are taken over by FHF staff, with administrative linkages to the NTL. This option achieves the ultimate separation of HIO's purchasing/contracting function from its service delivery function. The FHF contracts with accredited providers from all sectors including HIO, MOHP, Private and NGO.

This model assumes that expertise can be vested in the FHF staff thoroughly and completely, and that the FHF can contract with large numbers of organizations. It could be that when this model is adopted, segments of the HIO contracting organization will have been transferred into FHF, thereby reducing the risk that the FHF as a new organization will have difficulty in carrying out its duties.

3.5 Fiduciary Role of the Oversight Board

Whether the FHF is established as an account within HIO or set up as a true fund or Unit of a Special Nature, it was recommended that it be governed by an oversight board expressly designed to ensure that it carries out its special duties in a highly accountable manner. FHF books must be open to inspection wherever permitted under Egyptian law, as is consistent with sound financial practice. This oversight function is critical to the success of the FHF, and therefore warrants this special section describing the fiduciary role necessary for the board of oversight, by whatever its name and status, to perform.

"Fiduciary" literally means "position of trust" as the role of a board overseeing a fund. The role of a fiduciary board (board of trustees) is to provide oversight by a group of government officials and members of society who, in this case, have an interest in health administration in general, and the types of reform to be carried out under the auspices of PHR in particular. In the FHF pilot, the board will establish for itself a very strong position of trust beyond the usual meaning in the Egyptian context. That is, the FHF board will have standards built into its operating procedures, and its culture, which will make its members collectively responsible for the proper expenditure of FHF funds and the competent and efficient operation of the FHF contracting function. The board is not intended to replace the actions normally taken by staff or high administrators in the agencies of the HIO.

The board is meant to provide guidance and to act upon contractual and payment matters, as a body and not as a servant of the chair. For that reason, procedures and standards must be established to guarantee full disclosure and debate of all relevant facts leading to decisions, and to ensure that votes to approve contracts and payments are in accordance with sound business practice and the fiduciary principles of care and loyalty. Edmond (June 1999) discusses the fiduciary role in detail.

Figure 5. The Pilot FHF Base Model: Option 3

Requires Presidential Decree

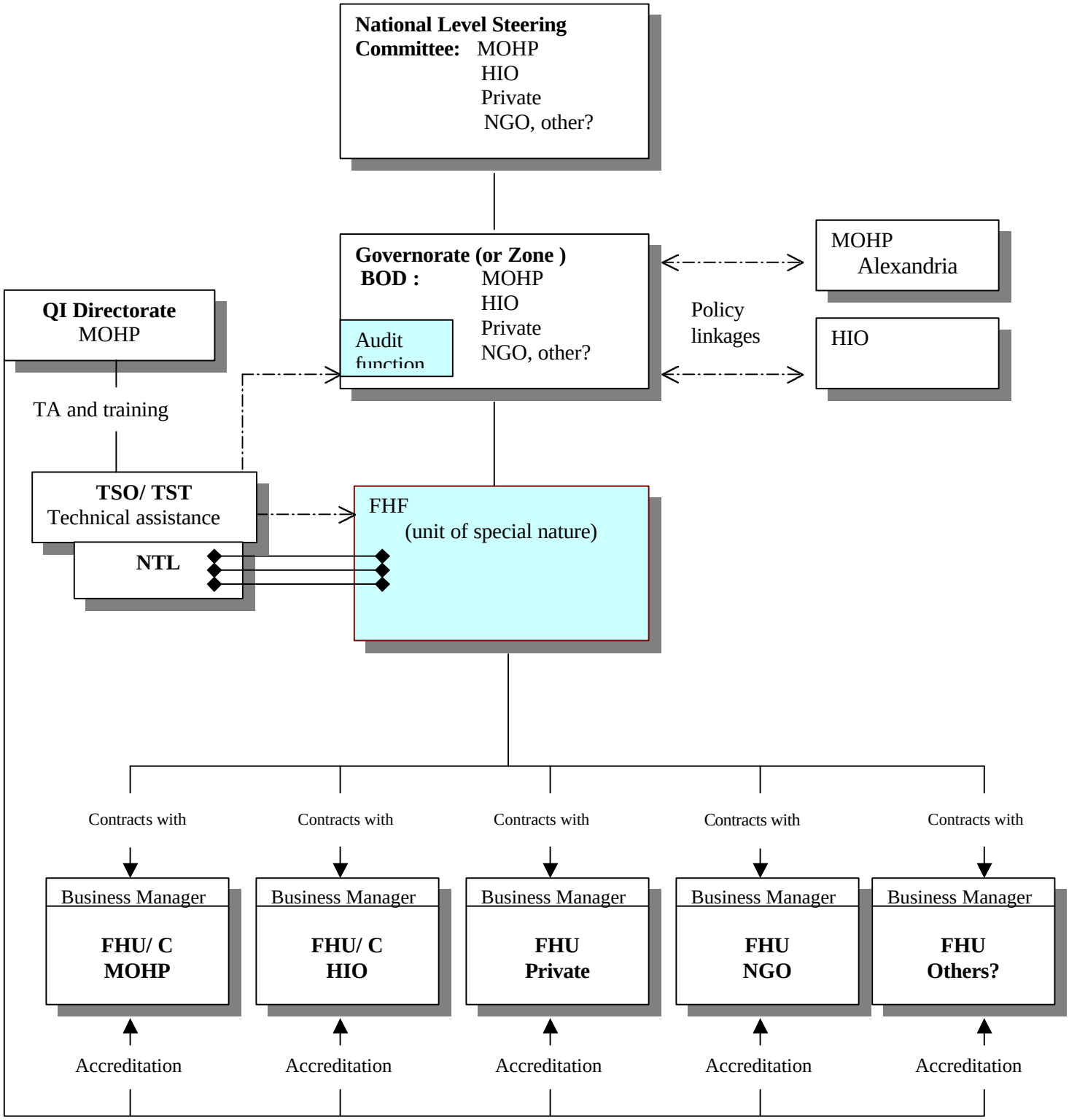


Table 1 presents a "checklist" which the Minister might use in setting up the FHF fiduciary board and in establishing its governing procedures. This checklist also shows some of the recommended characteristics of the board's membership, such as whether the members ought to be paid, be full-time members, etc.

Table 1. Checklist for Establishing and Maintaining a Fiduciary Board

Issue or Action Item	Recommendation	Comments
Membership: full-time or part-time?	Part-time	Most members will be from public agencies. Others will be from NGOs and other agencies, so will serve part-time.
Compensation of members	Stipends for attending meetings, as provided by law	Reasonable expenses should be provided for, but overall compensation should not be the motive to serve on the board.
Chairmanship	Elected by board members annually, rotating among members	The board should not be dominated by HIO or any other agency.
Powers of chair	Signatory, after a majority vote. Chair runs meetings by Robert's Rules of Order or equivalent.	It is critical that the signatory power of the chair is used only after full board discussion of the matters at hand. All members, not just the chair, are responsible for actions the board takes.
Status of meetings	Open to the public, except as the law provides secrecy for proprietary issues or to discuss personnel matters	Meetings should be held on a scheduled basis where possible, with enough notice for staff to prepare agendas for study by members before the meetings.
Records of meetings	Open for public inspections, except portions deemed by a majority vote to be proprietary or personnel related. At each meeting the board votes on minutes of prior meeting, as presented by a recording secretary (member of board elected by the board).	Most actions taken will be of a financial nature, and will be subject to an audit.
Staffing	Coordinator reports to branch director daily and to chair on a regular basis.	Audit unit's status to be determined. May be staff, or may retain reporting relationship to MOHP or to Minister directly. Regardless of status, must make periodic financial and management audit results available to board in full.
Staff participation at meetings	Coordinator helps organize, and attends all meetings, has the right to speak. TST and TSO may attend and may request to speak.	Staff and TST/TSO will be involved in the details of a new system of contracting and will have analyses and observations to present to the board. Board members should actively seek such analyses and encourage such structured discussions on a regular basis.

Issue or Action Item	Recommendation	Comments
Audit unit	Carries out financial and management analyses	At least annually, meets with board to discuss standards to measure management performance of contractees. Critical for TSO/TST inputs at those sessions.
Reports	Annual audit report. Periodic staff reports and reports of audit function, for each contractee and as requested by majority vote of the board.	Two-way communication with branch director and his contracting experts is critical.
Ethics code	Board adopts a code, based on international models and adapted to Egyptian conditions.	At a minimum, defines conflicts of interest, removable behavior of board members, procedures for investigating complaints about members, and sanctions to be taken and by whom.
Removal of board members	For violations of ethics or laws, or excessive absence from meetings. Removal voted by board and approved by the Minister, who appoints a replacement.	
Relationship with contractees	Contractees are kept at “arm’s length.” All business with contractees is done in open meetings.	It is very important to avoid even the appearance of a conflict of interest involving contractees.
Confidentiality of board’s records	Access to records determined by board and set out in writing. Chair decides on release of records, subject to appeal to full board and then to the Minister.	Secrecy applies only to names of doctors, patient records, and other privacy needs. Secrecy may not apply to performance standards or overall performance of contractees.
Appeals of board decisions	Contractees may issue appeals in writing and in a timely manner, and appear before the board at the next regularly scheduled meeting. Substance of appeals can be: fairness of payment made, rejection or non-renewal of a contract, or an error having a negative impact on contractee’s payment.	Board does not discuss performance of individual employees of contractees, but only the performance of contractees as measured against standards applied to all of them.

3.6 Issues and Lessons Learned Affecting Implementation

Edmond (June 1999) recommended specific implementation actions to operationalize the FHF as a pilot quickly to meet contractual deadlines and benchmarks. However, it soon became evident that prior to the establishment of an FHF, even in pilot form, more consultation had to take place among all the stakeholders, and a training event was held in Alexandria to discuss the strengths, weaknesses, opportunities, and threatening elements of an attempt to institute the FHF. This training event and other consultations revealed the following policy and institutional issues that might slow implementation:

> Perceived diminishing of HIO as the prime contracting agency of the MOHP, resulting in a fragmentation

> Uncertainty about the financing options for family health care that would be available and feasible, given government funding limitations and the users of health services having customarily received care for free or nearly free

> Possible rejection by some stakeholders of a fiduciary body that would operate outside the direct control of the ranking HIO official in the geographical area

> Bureaucratic rivalry over prerogatives and traditional roles in accreditation, oversight, signatory powers, and review of standards to be applied to contractors and the health care delivery system itself

> Insufficient knowledge about performance-based contracting and uncertainty about what staff would carry this out and where they would get their training

> Insufficient communication among stakeholders in general, and lack of information about what mechanisms could be put in place in a short period of time to insure a better flow of data to support the new mechanisms for implementing performance-based contracting

> Lack of a business planning tradition and practice that will be necessary to record and track progress against predetermined targets and success measures

> Apparent absence of a unified approach within the MOHP aimed at overcoming any legal and procedural impediments to a smooth implementation of pilot institutions and practices

> Confusion or misinformation about the types of legal and procedural changes that would have to be sought, and whether decrees rather than law changes would be sufficient in some cases (such as setting up sub-accounts of an FHF)

Most issues stem from the natural inertia found in large organizations facing changes perceived to be radical or threatening to the status quo. They therefore take on great importance to those who must adopt the new contracting culture and perhaps change their reporting relationships within the government structure.

There are several lessons learned regarding the details of the approach, such as:

> Start the internal communications process with more consensus on key assumptions, such as whether or not co-payments, roster fees, and other user contributions would be used in lieu of, or to supplant, a subsidy from the HIO budget.

> Have the recruitment process for key positions further along prior to the training and feedback session in Alexandria. Have a sense of what the MIS could and could not do to support performance-based contracting, given the limits in staff numbers anticipated early on.

> Have a solid estimate of the overall cost of implementation in hand, including the true costs of seconding, pay incentives, indirect program subsidies, etc, so the fiduciary Board of Trustees and others can try to meet internal cost goals of this type.

> Research and determine early on, the need for legal or legislative changes to enact a pilot effort, including the details of setting up sub-accounts for the FHF in its pilot stage. Given the sensitivity around HIO's mandated prerogatives in the health insurance sphere, having a dialogue among the legal experts earlier would have eased the process.

> Have a body of data sooner concerning the sensitivity of consumers of health care as to their financial participation in return for more effective and comprehensive care.

There are, of course, policy and budgetary reasons why nearly all of these actions could not be taken prior to the startup of the pilot phase. Also, it was not possible several months ago to assign proper weight to each action in terms of its importance to the pilot effort. In fact, some of the actions listed above were seen as crucial to the success of the pilot, but their absence was of necessity treated as a calculated risk.

3.7 Recommendations

In September 1999, a session was held with key stakeholders from the HIO, MOHP, TSO, TST, and PHR to discuss the three options, form a vision for the FHF, consider the various stakeholders who would relate to the FHF, and map out the next steps for the implementation of the FHF (see Section 2.7 for more detail of this activity). Throughout the consultative process, including the meeting with the Minister, the three options for organizing the FHF were treated as either stand-alone options or as sequential steps.

Given the fact that an existing contracting function exists within HIO, and given the long lead time necessary to bring about enabling legislation or a presidential decree to set up the FHF as a true "Fund," Option 1—an FHF account affiliated with HIO—was recommended. This would have unique administrative design characteristics and a fiduciary body solely involved in providing policy guidance, financial and quality oversight during the pilot stage of this project. However, Option 3 was considered from the start to be the most attractive and therefore a goal to be sought over time as the pilot efforts ran their course.

This collaborative discussion was accomplished without the benefit of a decision on a financing strategy for the pilot, without the MIS design having been finalized, and without having any FHF staff in place. An interim director of the FHF had been named, however, and was a participant and presenter in the sessions.

While the pilot program has proceeded without all the pieces in place as logic would dictate, the chance for success seems high at this time. Pilot programs are used to "show the way," and therefore any imperfections in design will be prominently reported so that policymakers can take corrective action as they proceed to rollout the reform initiative.

4. FHF Organization Design: Structure and Operational Principles

4.1 Objectives and Main Issues

The pilot project in Alexandria is implementing, for the first time in Egypt, the concept of a separation of health insurance payer functions from service provider roles. It establishes the Alexandria Governorate Family Health Fund to model this separation, representing the payer function or contracting agency.

In May/June 1999 recommendations were made for the internal organization design of the FHF based on principles for the development of a sound organization with clear accountability structures.

These principles included:

> A clear mandate for the organization as a whole as well as for each of its structural units

> An organization chart showing structural units and reporting relationships

> A description of each structural unit including broad statements of managerial responsibility

> A set of behavioral and accountability principles that will form the basis for a performance management system

> A mechanism for effective oversight of the FHF during the term of the pilot project

> A detailed description of the responsibilities and authority of the proposed governing structure and the nature of its relationship with the FHF Director

Specific recommendations for each of these principles are discussed below.

4.2 Mission

Initially it was recommended that the mission of the FHF is to ensure that high quality health care services are provided to the population of the North West Delta region of Alexandria, by means of:

> Wise care and investment of collected insurance funds,

> Cost-effective purchase of health services, and

> A pay-for-performance system of contracting with health professionals that motivates them to contribute their very best work.

When this mission statement was developed, it was anticipated that the FHF would be the holder of all health insurance funds collected by the HIO on behalf of its beneficiaries as well as funds held by the MOHP for those covered by its service delivery program. Since that time, the concept of the FHF as an insurance fundholder has been scaled down to reflect the complexities of developing and implementing new health insurance legislation to replace that which currently exists.

It is now anticipated that initially the Family Health Fund will only collect annual patient roster fees (i.e., fees to register with a family health unit) to pay performance incentives to service delivery sites and referral providers that meet or exceed quality indicators specified in their service contracts with the FHF.

The Family Health Fund, therefore, is currently being viewed as a *quality contracting agency*, whose mission is to ensure that high quality health care services are provided to the population of Alexandria. This will be achieved by a pay-for-performance system of contracting with health professionals that motivates them to contribute their very best, as well as by cost-effective purchase of health services on behalf of beneficiaries.

Once the pilot project has been evaluated and actual cost data for the pilot project have been analyzed, accurate actuarial projections and total cost estimates will be made. Such analyses will permit options to be presented for changing the role of the FHF from a quality contracting agency to a true health insurance payer for the basic benefits package. It will also be possible, at that time, to consider expansion of the basic benefits package to include a broader range of services.

4.3 Operational Principles

The FHF will be an organization that is without precedent in Egypt today, in terms of the way it is structured and the manner in which it conducts its operational mandate of contracting with providers.

Boxes on an organization chart do not ensure long-term success. Rather, it is what goes on *inside* and *between* the boxes that is significant. The organization design recommendations for the FHF include, therefore, several behavioral and accountability principles specifically designed to encourage staff performance that will support achievement of the organization mission.

4.3.1 Behavioral Principles

Everyone in the FHF—and particularly the director and his subordinate managers, whose level and visibility make them role models for the rest of the staff—will be held accountable to certain behavioral principles:

> Commitment to individual responsibilities and to the organization mission

> Integrity in all dealings with government, community, clients, and all organization members

> Reliability

> Initiative

> A spirit of cooperation

4.3.2 Accountability Principles

All FHF employees, including those who are also managers, are accountable for:

> Their own personal effectiveness: bringing full capability and judgement to accomplish goals and assigned tasks

> Completing assigned tasks within agreed standards of quality, quantity, resource requirements and timeliness and, if unforeseen events make it likely that these standards cannot be met, providing their managers with feedback about how things are going, about the nature of the changing circumstances, and renegotiating the expectations

> Informing their managers about problems with work processes and making useful suggestions for improvements

> Modeling the organization's behavioral principles in all interactions

Managers at all levels in the FHF (including the director) are additionally held accountable for:

> The outputs of their subordinates

> Maintaining and supporting a team of subordinates capable of producing the required outputs

> Providing managerial leadership to subordinates so there is collaboration and commitment in pursuing the established goals

Every manager must have the capability to add value to the work of his/her subordinates through his/her managerial leadership. Managerial leadership has several components:

> Modeling the organization's behavioral principles in all interactions

> Setting context for subordinates by providing a "big picture" view, informing them about goals and issues which could affect achievement of the goals, ensuring that subordinates understand one another's work and how it fits together to contribute toward the achievement of the group's mandate

> Assigning tasks to subordinates within the framework of the responsibilities of their role/position and including measures of success

> Regularly providing performance feedback, both positive and negative

> Coaching subordinates for better performance and development

> Formal performance effectiveness appraisal according to processes developed by the Human Resource Services group

Because managers are held accountable for the outputs of their subordinates, they must have the authority to:

> Veto the appointment of any new subordinate (this means having the freedom to refuse to accept a subordinate who is unsuitable for the position for valid reasons)

> Decide the type of work assignments to be given to subordinates within the framework of the responsibilities of their roles/positions

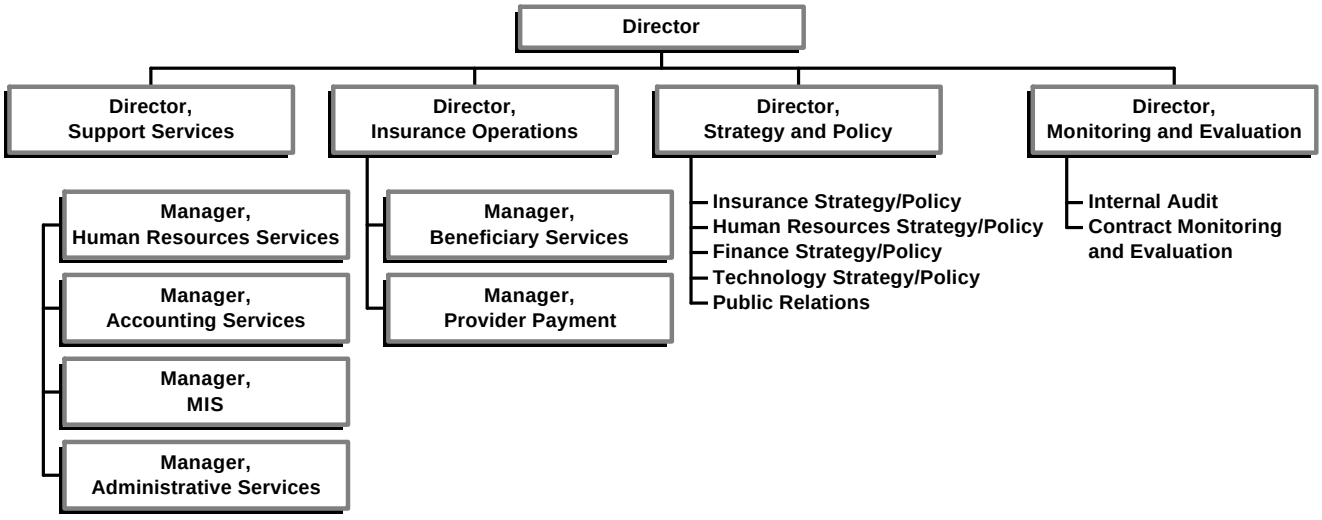
> Decide on the performance effectiveness appraisal of subordinates

> Decide to remove a subordinate from his or her role/position for valid reasons related to performance (not necessarily removal from the organization)

4.4 FHF Internal Structure and Responsibilities

The proposed internal structure of the FHF consists of four units: two divisions, Insurance Operations and Support Services, and two groups, Strategy and Policy, and Monitoring and Evaluation (see Figure 6). The directors of all four units report to the FHF director. This structure was determined by the nature of the contribution each function will make to the achievement of the mission. This section describes the role and responsibilities of the FHF director and her/his four subordinate directors.

Figure 6. Organizational Chart 1—Alexandria Governorate Family Health Fund



Mission

The mission of the Alexandria Governorate Family Health Fund is to ensure that high quality health care services are provided to the population of Alexandria, by means of:

- A pay-for-performance system of contracting with health professionals that promotes productivity, good clinical practices, and national use of drugs and referrals
- Cost-effective purchase of health services

4.4.1 Responsibilities of the FHF Director

The FHF director is accountable to the governing structure (Board of Trustees) to ensure the FHF fulfils its mission while operating within the behavioral and accountability principles. S/he will receive strategic guidance, direction and governance from the Board of Trustees and will be held accountable by them for conducting all FHF operations with integrity and according to financial, legal, and ethical standards for accounting and financial reporting.

The director is responsible for all strategy and policy decisions that provide the boundaries within which the FHF operates. S/he is also responsible for ensuring that the FHF meets the highest standards for efficiency and effectiveness in the administration of provider contracts, the appropriate payment for provider services, and the various interactions with current or potential patients.

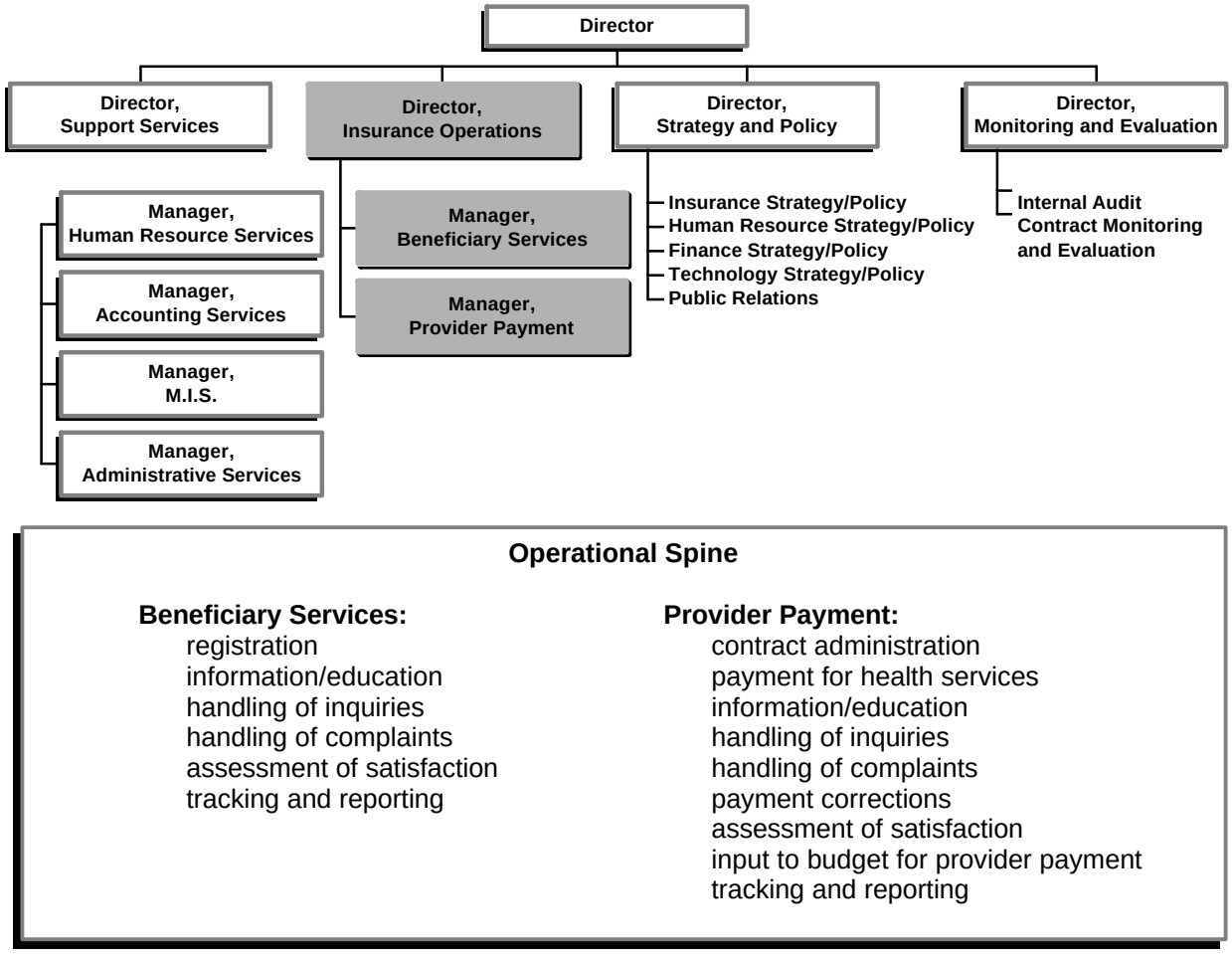
There could be conflicting pressures among these functions. The director needs to be a proven team builder, who takes this responsibility seriously, to ensure that the various divisions of the FHF work together toward their common goal and that no one unit or manager dominates. Because the director is also accountable for the outputs of subordinates, s/he must ensure competency in the management team and a spirit of support and cooperation among its members.

4.4.2 Insurance Operations Division

The Insurance Operations Division (see Figure 7) is the operational spine of the FHF. The Insurance Operations Division will perform the business functions that reflect the FHF mission to pay performance incentives to providers. This division has two departments: Beneficiary Services and Provider Payment. The primary responsibility of the director of Insurance Operations is to balance the mandates of the two departments, while ensuring that each provides the highest possible levels of client service.

The Provider Payment Department is responsible for the administration of performance contracts and payment of incentives. Staff in this department will be required to work closely with the Strategy and Policy, Monitoring and Evaluation, and MIS groups in order to ensure that payment to service providers is fully consistent with the intent of the performance indicators and submitted service provider performance data. As the pilot project progresses, the Provider Payment Department will assume responsibility for working closely with the pilot service delivery site teams to support continuing improvement of their performance. This will include explaining the implications of the regular performance reports received from FHF and providing processes for effective use of the information.

Figure 7. Organizational Chart 2—Alexandria Governorate Family Health Fund



It will be natural for the Beneficiary Services and Provider Payment Departments to compete for resources. The FHF director must ensure that both departmental directors receive what is needed and that each understands and supports the work of the other. This challenge can be met through the director's leadership and the division's common goal, to contribute to achievement of the FHF mission.

Other responsibilities of the director of Insurance Operations include input on the strategic decisions of the FHF director, input on the work of the Strategy and Policy Group and on the data collection efforts of the Monitoring and Control Group. The director is also responsible for validating, compiling, analyzing and submitting to the director, reports produced by the tracking and reporting activities of the Beneficiary Services and Provider Payment Departments.

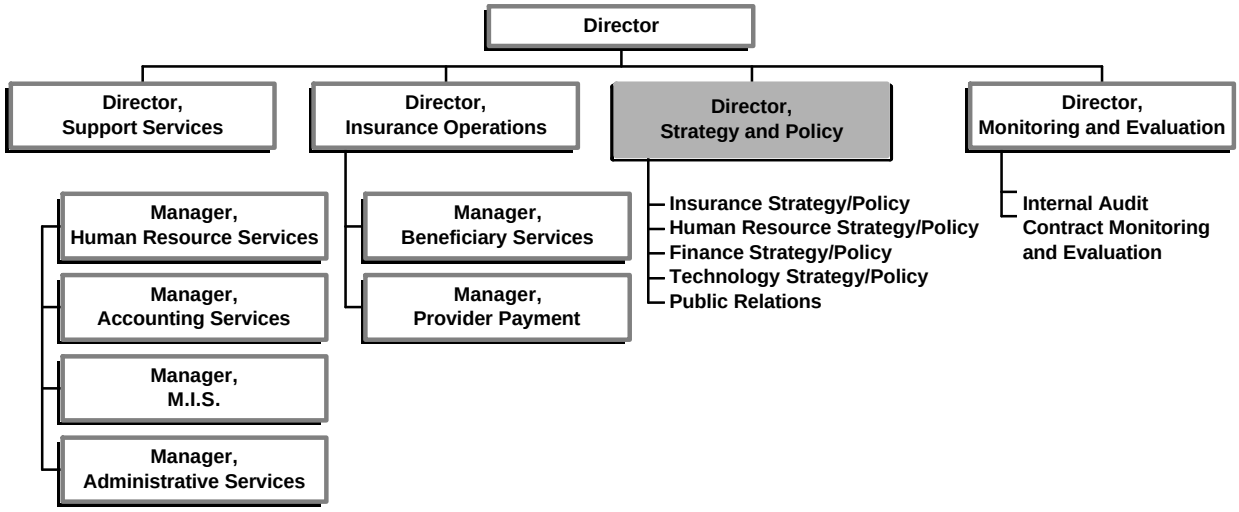
4.4.3 Strategy and Policy Group

The Strategy and Policy Group (see Figure 8) is responsible for recommending to the FHF director, new performance contracting indicators as part of an overall strategy to sustain and gradually improve the quality of primary health care services over time. It is essential that this group grasp the full impact of its role. Especially important is an understanding that the FHF and its contracted

service delivery sites are partners, *not* competitors, in the delivery of quality primary health care. The Strategy and Policy Group will collaborate with providers at the various sites in the development of new performance indicators. It will ensure that providers are well informed when new indicators are added to the incentive payment requirements, and give adequate lead-time for new learning to occur.

The Strategy and Policy Group will track the effectiveness of its performance indicators using regular MIS reports. It will also receive input from the Monitoring and Evaluation Group and work collaboratively with the MOHP Quality Improvement Directorate.

Figure 8. Organizational Chart 3—Alexandria Governorate Family Health Fund



Strategy and Policy

This is a group of highly skilled professional staff specialists operating at a managerial level, but with little or no reporting staff. They offer expert advice and recommendations, together with the research data and analyses to support their work, as input to the decisions about strategy and policy that are made by the director.

Insurance: e.g., actuarial projections; benefits package changes; ideas for collection of funds; approaches to contracting with providers
Human Resource: e.g., career and succession planning; leadership development; recruitment strategy and policy
Finance: e.g., strategies for investment of collected insurance funds to ensure growth prior to expenditure on provider services, ensuring adequate cash flow and liquidity to meet current obligations; budgeting, accounting and reporting frameworks and processes
Technology: e.g., organization-wide technology hardware; software to support information, planning, and control systems; claims payment system
Public Relations: e.g., FHF image in the community and beyond, alliances and networks to enhance service to beneficiaries and attract best providers; broad educational campaigns focused on expectations for quality service; advocacy on behalf of beneficiaries

Members of this group are highly skilled staff specialists in their field of expertise, operating at a managerial level. They will likely not have subordinate staff, although they will have access to administrative support.

The major responsibility of the director of the Strategy and Policy Group is to assess impacts of the interplay between recommendations made in a number of areas: insurance strategy/policy, human resource strategy/policy, financial strategy/policy, technology strategy/policy, and public relations. Responsibility is to determine the optimal set of recommendations to guide the decision making of the FHF director.

The director of Strategy and Policy is responsible for a small group of highly skilled professional staff specialists. It will be critical that s/he builds a team in which members cooperate to the fullest extent in the development and assessment of the recommendations they make on behalf of the FHF director.

The director of Strategy and Policy is also responsible for ensuring that s/he and group subordinates have access to a broad network of external sources of data, environmental trends, and expertise, in order to formulate their strategic recommendations.

A common problem that can emerge is that the Strategy/Policy Group becomes so distanced from the everyday operations of the organization that the policies they recommend are impractical either politically or operationally. The director of the group must ensure that policy development has input from FHF operations managers and is tested with them.

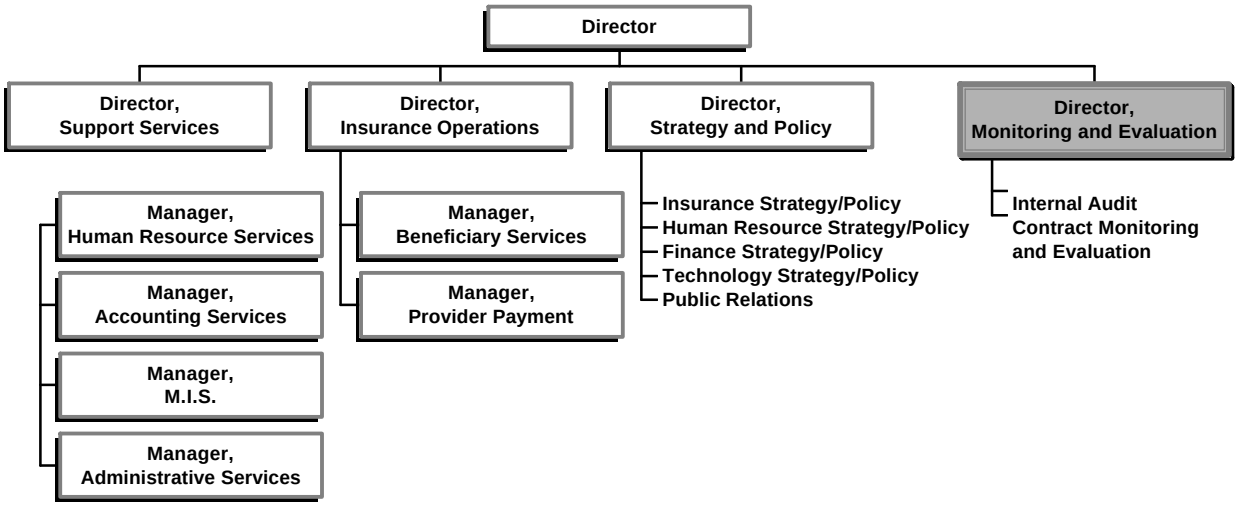
4.4.4 Monitoring and Evaluation Group

The Monitoring and Evaluation Group (see Figure 9) is responsible for ensuring that service provider pilot sites are correctly collecting and submitting performance indicator data using the encounter form mechanism. When problems are identified, it is this group's responsibility to identify the family practice doctor involved and work with the director of the family health unit to provide performance coaching as well as to track future activities so the problems do not recur. In the rare situation where difficulties continue, it may become necessary to involve the family health unit director, FHF director and the senior manager within the health sector to which the doctor belongs, in the decision to remove him/her from the service provider site.

The Monitoring and Evaluation Group is also responsible for monitoring the validity of the performance indicators, tracking over time whether they are achieving the service provider behaviors they were intended to achieve and whether those behaviors are contributing to quality primary health care. It will be critical that this group works closely with the Strategy and Policy Group (see Figure 8) to ensure understanding of the intent of the performance indicators and to indicate instances where the indicators are not achieving desired outcomes.

This group is intentionally separate from both the Insurance Operations and the Accounting Services sections of the FHF, so that it can maintain its objectivity. The FHF director's accountability for the integrity and ethical use of health insurance funds is supported by the work of this group. This is also a small group of highly skilled professional staff specialists, operating at a managerial level.

Figure 9. Organizational Chart 4—Alexandria Governorate Family Health Fund



Monitoring and Evaluation

This is a group of highly skilled professional staff specialists operating at a managerial level but with little or no reporting staff. They are intentionally separate from both the Insurance Operations and the Accounting Services sections of the FHF, so that they can maintain their objectivity. The director's accountability for the integrity and ethical use of health insurance funds is supported by the work of this group.

Internal Audit:
assessment of accounting methods
accuracy of financial reports
assurance of ethical investment of funds

Contract Monitoring and Evaluation:
accreditation of participating providers
contract review, monitoring
quality assurance
monitoring of payment for drugs
protocols and standards for provider service

The director of the Monitoring and Evaluation Group is responsible for ensuring that the entire FHF organization is meeting financial, legal, and ethical standards for:

> Collecting and managing FHF patient roster fees to be used for provider incentives

> Accounting and financial reporting

> Administration of provider contracts

> Appropriate payment for provider services

In addition, the director is responsible for conducting inspections to ensure that the service delivery pilot sites operate with integrity and honesty according to the contracted performance standards. S/he will have to balance the pressures of both an internal and external focus as well as work with FHF colleagues to support them in achievement of their mandates while ensuring that they are not engaging in illegal or unethical practices.

To carry out these responsibilities, the director of Monitoring and Evaluation must build a team of highly professional subordinates whose professional and ethical standards ensure that they will remain objective and honest in all their dealings with FHF colleagues, as well as with contracted family health service providers.

4.4.5 Support Services Division

The services to be provided by the Support Services Division are vital to the productivity and value of the human, monetary, and physical resources of the FHF (see Figure 10). It is recommended that these services reside within departments in this division. However, depending upon changing circumstances such as the size of the FHF, specificity of needs within each of its operational groups or divisions, cost-effectiveness, availability of services and/or competent staff, there are other models for inclusion of these services. These models are: locate the services within a division or group, purchase services from outside the organization, retain services centrally, or some appropriate combination of these options.

The MIS function of the FHF, which supports collection of data from service delivery sites and associated feedback reports as well as internal FHF data collection and reporting, resides its own department within the Support Services Group. The MIS Department is responsible for all MIS activities (see Chapter 6). In addition, it is responsible to generate and submit regular tracking reports to each FHF department, in support of internal FHF performance. Strategic decisions concerning FHF policies related to intra-organizational confidentiality, access to distribution of reports, technical support, systemwide hardware, software, and approaches to technical training are made by the FHF director, based upon recommendations from the Strategy and Policy Group.

The main responsibility of the director of Support Services is to integrate the various activities of each of the division's service departments within a framework of cost-effective, high quality, client focused, delivery of support services.

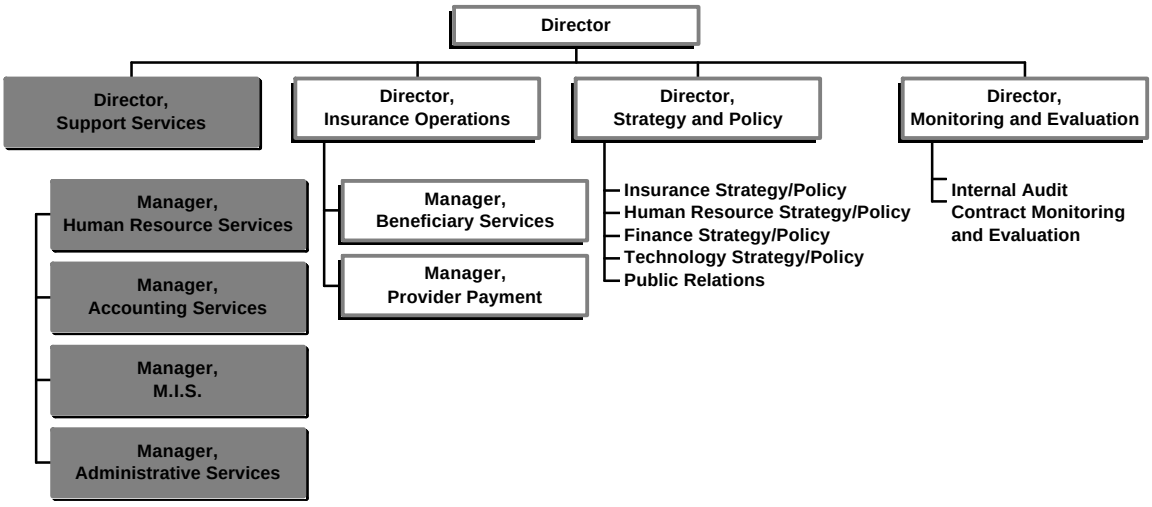
It is natural for a support services group to fall into the trap of trying to justify its own existence, whatever the cost to the organization. The FHF director will hold the director of Support Services accountable for tracking the cost and client satisfaction levels of the services provided to ensure value for money.

4.5 Conclusions

As mentioned earlier, the goal of the Alexandria pilot project is to model the various components of an effective system for family health care. Sustainability of the family health model will occur via the linkages between the FHF and the other organizational components of the pilot project through performance contracting and provider payment operations, fully supported by MIS system data collection, tracking, and reporting functions.

Perhaps the greatest challenge to the effective functioning of the FHF is the ability of its director and his/her management team to work collaboratively rather than competitively. It will be critical that everyone understands that a single director, division, or department within the FHF cannot be judged successful unless the entire organization is successful.

Figure 10. Organizational Chart 5—Alexandria Governorate Family Health Fund



Support Services

These are FHF-wide support services. The issue of whether to include them in a central group, as is recommended, or allow units to provide for themselves or purchase them from outside the organization on an "as needed" basis is one that is dependent upon changing circumstances, such as size of units, specificity of needs, cost, availability of services, and/or competent staff.

Human Resource Services: recruitment, payroll, human resource information, support to managers for hiring/firing; employee relations; training and development; performance management system; tracking and reporting
Accounting services: development of budgeting processes; support to managers for budgeting; accounting; tracking cost of business; development of budget for provider payments (with input from provider payment group); other tracking and reporting
Management Information Systems: technical support to FHF; technical support to providers; training for new hardware, new software; production of data and reports for use by FHF managers and others as appropriate
Administrative services: maintenance of building and surrounding property including adherence to highest standards of health and safety; maintenance of physical equipment within the building; maintenance of FHF-owned vehicles; planning and implementation of moves within the building; travel arrangements; accommodation arrangements; maintenance, set-up and reservation of meeting rooms; meeting support; purchase of common materials (e.g. desks, cabinets, pens, stationery, etc.)

5. Family Health Fund Incentive Payment System

The structure of the incentive payments to service providers requires careful thought following an analysis of encounter form data. Incentive payments should be meaningful and earned rather than simply routine. The specific structure of the incentive payments should be determined in discussions with FHF staff (the *quality contracting agency)* and service providers in the family health pilot sites. The importance of the data collection methodology, data accuracy, and data analysis for monitoring by the FHF cannot be over-emphasized.

The FHF incentive payment system should be automated, totally objective, and based on data that cannot be challenged. The system must be transparent so providers in the pilot sites can trust the system and have confidence that they have the ability and opportunity to improve their performance to meet standards. Prerequisites for the FHF performance contracting and incentive payment system include:

> A beneficiary registration system with a unique patient identifier

> A unique provider identifier

> An MIS for the FHF in which performance standards are programmed into the incentive payment automated system

> Accurate submission of encounter data from the service delivery pilot sites to the Family Health Fund Management Information System (FHF-MIS)

5.1 Procedures for the FHF Incentive Payment System

The procedures for roster fee collection, data collection and processing, and payment of incentives by the FHF are as follows:

> Roster fees are collected from or on behalf of every patient who registers at the service delivery pilot sites.

> All roster fees collected are sent to the FHF.

> Ten percent of roster fees is retained at the FHF for administration costs, and another 10 percent is retained at the FHF for its reserve fund. The balance of roster fees is available for incentive payments by the FHF; any unused portion is placed in the reserve fund.

> The encounter form originates at the time the patient first enters the service delivery site; a serial control number is assigned at this stage.

- The form is placed in the family folder, which is sent to the family practice room by clinic staff: the encounter form and the family folder are not given to the patient to take to the FP room.

- The FP team examines and treats the patient and records necessary encounter data on the encounter form in the specified format.

- Encounter form data are entered daily into the patient-based system at the service delivery site.

- Interface between the patient-based system and the FHF ensures that information is passed routinely to the FHF for contract administration.

- Edit controls in the FHF-MIS ensure that all serial encounter numbers are present from each service delivery site, that there are no duplicate or missing numbers, and that all necessary encounter information is present.

- The FHF-MIS accumulates encounter forms until month end and then produces monthly management reports indicating performance compared to indicators at the FP team level as well as at the level of the service delivery pilot site.

- Monthly incentive payments are made to the service delivery pilot sites as a whole based on achievement of performance indicators.

- The director of the service delivery pilot site determines the apportionment of incentive payments to individuals at the site, based on established criteria.

- FHF monthly reports are used by the management teams at the service delivery pilot sites to review performance and implement improvements.

5.2 FHF Performance Indicators for Contracted Providers

The FHF, as the *quality contracting agency*, is responsible for ensuring that the pilot sites deliver high quality services. This involves setting quality standards in collaboration with providers and establishing mechanisms to monitor whether those standards are met so the FHF can make incentive payments to providers who meet or exceed those standards. Monetary incentives have been found to be powerful motivators for physicians and other health providers in Egypt. The performance-based contracts between the FHF and each pilot site will stipulate the mechanisms and conditions under which the FHF would make incentive payments.

The whole process must be transparent. There should be no surprises to providers about expected performance levels or the methodology used to evaluate performance. However, since this is a pilot project, different mechanisms will be tested and evaluated by the FHF and standards may have to be re-established based on such evaluations. All of this will be done through consultation between the FHF and providers who participate in the pilot project at the service delivery pilot sites.

The performance indicators to be developed by the FHF should address known problems that impact the quality of care within the health care system in Egypt. Some of these are:

- Poor attendance and punctuality on the part of employed service providers

> Lack of attention to patient satisfaction

> The tendency of primary care physicians to simply refer patients to specialists rather than to treat them

> High utilization and cost of drugs

The performance indicators should also encourage providers to:

> Implement and integrate established vertical sector programs and achieve results indicators for these programs

> Reduce patient wait times

> Provide preventive health care and lifestyle counseling

> Promote good health outcomes in their rostered population

Six categories of performance indicators are designed to promote high quality health care.

1. Productivity indicators

Productivity can be measured by number of patients seen. The purpose of this category is to ensure that family practice teams carry their fair share of the workload within the family health unit. This category will also account for attendance levels by family practice teams, since poor attendance will reduce productivity.

2. Customer service indicators

These are based on a measurement of customer satisfaction, as determined through the administration of a standard scientific instrument, such as a survey. The survey will determine patient views on how they were treated by the staff at the family health unit, how they view the cleanliness of facilities, how long they waited for treatment, etc.

3. Quality indicators for vertical programs

Vertical programs are those MOHP and donor-supported programs that relate to a single medical objective, such as immunizations for children or family planning. Indicators in this category will be determined through consultation with vertical program staff with the involvement of the Quality Directorate, and would include such standards as the contraceptive prevalence rate among rostered women of childbearing age and the rate of immunization in rostered children. Emphasis in this category will initially be on established MOHP vertical programs.

4. Drug volume and cost indicators

The intent of this category is to reverse an established trend in Egypt towards over-medication or self-medication of patients. This is one category where it may be more effective to have a “negative incentive,” i.e., a penalty or deduction from other incentive payments, to curb high prescription rates.

5. Referral volume indicators

This category is designed to encourage physician and nurse teams to treat patients themselves, within their area of competence, rather than simply refer them to specialists for treatment. Trainers from Exeter University estimated that fully competent family doctors should be able to treat 90 percent of cases presenting for primary health care. In the Egyptian context, it may be more appropriate to start with a lower limit of, say, 80 percent. A thorough analysis of actual experience should assess whether this target could be raised, particularly given the lag in family medicine training.

6. Health outcomes for rostered patients

The ultimate aim of all health care systems is to improve the health of patients seen. Monitoring health outcomes requires sophistication to track the health of the rostered population, using techniques such as control group comparisons or outcome evaluations that meet internationally recognized standards.

7. Maintenance of facility accreditation

Incentive payments must encourage facilities to maintain certain operating standards on an ongoing basis, such as cleanliness, hours of operation, staff attendance, etc. It is very important not to let facilities compromise such standards, since that would ruin the image and positive outcome of the pilot project, reduce the competitiveness of the facility, and reduce patient loyalty and support. Through the pilot project, facility accreditation by the Quality Directorate of the MOHP will become a much-valued commodity. Since accreditation involves ongoing inspections and evaluations, service delivery pilot sites will strive to maintain their status as an accredited facility.

5.3 Implementation issues

5.3.1 Technological support and infrastructure

The objectivity, transparency, speed, and accuracy of the entire contracting and incentive payment system depend heavily on integrated automated technological systems for collection and processing of data. However, acquisition of technology may take time. Some service delivery pilot sites have been functional for many months (Seuf for six months) but still do not have basic communications amenities such as telephone lines or fax machines. Where piecemeal computer acquisitions have occurred, local area networks are not yet in place in all facilities and staff have not yet been trained for proficient use of the technology.

To bridge the gap between manual systems and full automation, the encounter form has been designed for manual completion at the service delivery pilot sites even though its production may be automated in the future. At the FHF, however, it is vital that there is an automated system for administering the contracting and incentive payment system.

5.3.2 Training

Training is also an important component of the contracting and incentive payment system in the pilot project. This includes training of service delivery pilot site staff in:

> Procedures for encounter form submission

> Management processes for review and follow-up of FHF reports

> Use of personal computer technology

> Methods for ensuring control and accuracy of data.

Training is also required for FHF staff, once the FHF is established and staff have been hired. Technical training will be required in operational procedures, in the details of the FHF-MIS, and in accounting systems. Management training will be required both for internal management processes within the FHF and external relationships between the FHF and the service delivery pilot sites.

6. Family Health Fund Management Information Systems

The Family Health Fund Management Information System will become the basis for data collection, information and statistical systems, and contract administration for FHF operations. These systems will also provide important information on health care service delivery, cost, and quality to the Ministry of Health and Population. The FHF-MIS will also provide data on patient encounters to the designers of national health insurance systems through the National Technology Laboratory.

The FHF-MIS will support the following important activities:

> Identification of beneficiaries based on a unique beneficiary number

> Identification of providers based on a unique provider number

> Performance-based contracting

> Identification of the status of contracted facilities

> Health care services and FHF costing and budget analysis

> Actuarial analysis to support planned national health insurance systems

> Feedback on services provided by contracted facilities

> Patient encounter data standardization and data quality monitoring

> Recommendations to the High Committee for Health Insurance on development of data policy.

Following sections discuss each of these activities.

6.1 Identification of Beneficiaries

A unique beneficiary number that is tied to the beneficiary rather than to the facility, district, or governorate is an essential feature of the FHF-MIS. This beneficiary number will allow accurate tracking of beneficiaries regardless of their choice of FHF provider. It will also allow accurate tracing of beneficiary episodes of care including the site of primary, referral, and district hospital services. Finally it will support the transfer of family files if a beneficiary changes their primary provider or moves to another family health unit.

6.2 Identification of Providers

Analysis of provider performance is the basis for the performance-based contract that will allow the FHF to reward excellent quality. The provider identification is also important if providers practice in two locations, only one of which is a contracted Family Health Fund site. Comparative analysis of provider performance will allow the FHF to describe realistic performance expectations, and to gradually increase the level of performance required to earn an incentive.

6.3 Performance-based Contracting

The FHF-MIS has a primary purpose to support the administration of the performance-based contracting with providers in the MOHP, HIO, NGO, and private sectors. In order to fulfill this purpose the FHF-MIS will collect and track standardized patient encounter data on a regular basis from all contracted providers.

The FHF will develop reporting standards for submission of data by each service provider, using the encounter form. The FHF-MIS will be a prototype, receiving the standardized data from each contracted facility and producing regular reports for use by the FHF and the service delivery pilot sites for performance tracking and continuous improvement. The FHF-MIS is not intended to be a patient-based clinical system or an automated medical records system. Rather, the FHF-MIS begins to model a data collection and processing system for health insurance that applies data standards for the reporting of each patient encounter, and receives the standardized data from each contracted facility.

The FHF-MIS system produces comparative reports based on the standardized encounter data received. It provides data to the FHF provider payment department to allow payment of incentives based on the efficiency and quality of the patient services provided, as measured against predetermined performance criteria.

6.4 Accreditation

The MOHP Quality Directorate is responsible for the accreditation of facilities that are prepared to contract with the FHF. The accreditation status of each facility will need to be collected and stored by the FHF-MIS. Additional information on each contracted facility may also be required, and the FHF-MIS will develop the capacity to design and implement a contracted facility database.

6.5 Cost Analysis

The FHF-MIS will require a cost tracking and budgeting module that will enable the FHF to estimate the cost of providing the basic benefit package of services and the cost to operate the FHF itself. Development of accurate cost accounting information will allow the development of both standard costs and FHF budgets. The budget and cost data will form the basis for budget monitoring and budget variance systems that will support FHF operations.

6.6 Actuarial Analysis

Performance-based contracting is only the first step in the development of a system capable of supporting national health insurance. The data necessary to develop actuarial analyses that can support capitated or mixed payment systems can be developed in large part though the FHF activities in provider contracting. Patient encounters and costing systems provide essential information for actuarial analysis of risk that allows development of national health insurance tied to the basic benefit package. The FHF-MIS will need to report accurate and reliable data to the NTL to support this activity.

6.7 Feedback on Services Provided by Contracted Facilities

The FHF-MIS will produce reports that are sent back to the contracted service delivery sites. These reports will indicate strengths and weaknesses in provider performance and will allow the management teams at service delivery pilot sites to develop and implement performance improvement strategies. Feedback reporting also provides a data accuracy check, since facilities and providers will have an opportunity to review the basis for incentive payment and provider performance monitoring.

6.8 Patient Encounter Data Standardization and Data Quality Monitoring

The FHF-MIS will need to apply data standards for all service delivery sites that contract with the FHF. These standards will allow migration of data from the clinical systems in each facility to the FHF-MIS. The systems at the facilities may need to perform many functions that are outside the required reporting standards for the FHF-MIS. For example, personnel monitoring required in MOHP facilities will be tracked by the MOHP, not by the FHF-MIS. It is the responsibility of the FHF-MIS to communicate data standards clearly to the contracted facilities and providers, and to provide adequate support and training to allow these facilities to comply with the data standards described.

Data quality monitoring is an additional function of the FHF-MIS. Procedures for assuring data quality will need to be described and a protocol for monitoring of data reporting from the contracted facilities and providers initiated. Both the FHF Board of Trustees and the High Committee will require a periodic report on data quality monitoring activities in the pilot project.

6.9 Contribution of the FHF-MIS Reporting Systems to Policy Development by the High Committee for Health Insurance

The FHF will be a strategic partner with the MOHP, the HIO, and other contracted providers to recommend data policies to the High Committee for Health Insurance.

Policies and guidelines will be required in the following important areas:

> Confidentiality of patient records and encounter data

> Patient rights to clinical and provider information

> Ownership of clinical and encounter data

- Public access policies to clinical and encounter data
- Provider confidentiality, particularly in regard to performance reporting
- Use of aggregated encounter data by private insurance and health providers
- Use of clinical, cost, and aggregated encounter data by MOHP vertical programs
- Data storage and security
- Data reporting to international agencies
- Use of aggregated data by the research community

Policies in these and other areas will need to be carefully considered and defined by the High Committee on Health Insurance. The FHF-MIS will provide useful analytical data to guide these decisions.

6.10 Future Development of FHF-MIS

As the pilot project proceeds, the FHF-MIS could be used for such activities as:

- Tracking training provided to family doctors and nurses to provide input to a family practice accreditation program at the provider level
- Providing data on patient health outcomes over time
- Providing data for actuarial projections for utilization of services by age, gender, income level, etc.
- Providing statistics for governorate or national level planning

7. Communications and Marketing for the Establishment and Launch of the Pilot Family Health Fund

Communications and marketing are critical to the establishment and launch of the FHF, as they have been to the entire health reform program in Egypt. These activities facilitate the development of the FHF as the institutional "lynchpin" tying together the service delivery, financial, and regulatory policy reforms required to effect the transformation of the primary health care system. They are of ongoing importance to FHF strategic planning and management.

Communications and marketing activities for the FHF are divided into two phases:

Phase 1: Diverse policy communications activities to foster consensus-building and understanding of proposed policies for the establishment of the FHF.

Phase 2: After the FHF is established, continued policy communications to enhance understanding of the FHF's role and objectives among implementers and policymakers; plus marketing activities to promote provider participation in the FHF and patient enrollment in a pilot project service delivery site.

FHF communications and marketing activities are geared to specific target audiences and serve five distinct purposes:

> Consensus-building and policy decision making (Phases 1 and 2)

> Awareness and capacity-building (Phases 1 and 2)

> Marketing and public relations (Phase 2)

> Health promotion (Phase 2)

> Public information (Phase 2)

This section describes accomplished and ongoing work related to communications and marketing in Phase 1 leading to the establishment of the FHF, and then briefly outlines future steps and implementation issues for communications and marketing in Phase 2.

7.1 Phase 1

7.1.1 Communications and Marketing Strategy

PHR developed a marketing and communications strategy (see Terrell, August 1998) for the primary care reform, and consequently the FHF. This strategy began with identification of key

stakeholders and in-depth interviews with the Minister of Health and Population, managers and technical staff of the TSO, representatives of the HIO North West Delta Branch and academia, USAID Health, Population and Nutrition officers and other donor representatives, and staff of cooperating agencies and NGOs in the health and population sector. One focus group was also held with providers from the public and private sectors. A role-play exercise on customer relations at the first pilot clinic also provided insight into attitudes of doctors and nurses regarding customer satisfaction. These sessions, plus questions raised at meetings and formal presentations, revealed gaps in information needed to inform policy options and choices and therefore the need to elaborate and reiterate explanation and discussion of priority themes and new concepts imbedded in the policy reform.

The main policy themes related to the establishment of the FHF that were identified as priorities for the communications and marketing work were:

> Family Medicine: promoting the practice of family medicine among providers; promoting family health and seeking care from a family doctor/nurse team.

> Public/private Contracting and Provider Incentives: promoting provider methods that motivate delivery of efficient, quality, cost-effective primary and preventive care; promoting NGO and private sector family medicine practice and participation in the pilot project.

> Quality and Accreditation: promoting awareness of the quality improvement and accreditation process associated with the family healthcare model and the FHF; promoting acceptance of accreditation standards among providers and awareness among patients of accredited facilities. Acceptance and success of the FHF depends on understanding of its role not only as a financing entity but also as a guarantor of sustainable, quality services.

> Social Insurance: Promoting the FHF and reform goals to increase equitable access to cost-effective, quality care to protect the poor.

> Patient Satisfaction and Choice: promoting respect for the patient; mutual provider–patient respect; promoting concept of provider/facility competition for patients by maintaining good quality of care.

Acceptance of the new FHF and the willingness of providers and patients to join the pilot program is contingent on acceptance of the family medicine approach and the quality of the services provided by the service delivery pilot sites. Therefore, promotion of the FHF began and continues with promotion of the family medicine concept among providers and patients and the demonstrated delivery of quality primary curative and preventive services at sites that will contract with the FHF.

Furthermore the institutional autonomy proposed for the FHF requires support from both the HIO and MOHP. Autonomous status to distinguish the FHF from the old system and “good press” from the service delivery pilot sites are critical to projecting a new image and winning the FHF’s general acceptance and *trust* by potential client providers and patients.

7.1.2 Communications and Marketing Activities

7.1.2.1 Policy Communications

During Phase 1, the introduction of new policy concepts was designed to raise awareness about proposed policy reforms and to build consensus for the reforms. Presentation of specific policy options based on qualitative and quantitative research and the outcomes of the consultative and consensus-building process have been used to promote decision making. Policy communications activities have included the informational seminars and consensus-building workshops described in Chapters 2 and 8; the dissemination of policy/discussion papers (decision briefs), informational briefs and other publications; and formal presentations and informal briefings to top decision makers and key stakeholders at the central level of the MOHP and in the pilot governorate. Advocacy among political stakeholders (Parliament, Presidency and the Cabinet, Medical Syndicate, among others) and press relations are exclusively handled by the Minister.

7.1.2.2 Market Research and Dissemination Activities

Phase 1 has made extensive use of qualitative marketing research activities, such as in-depth interviews and focus groups, targeting specific stakeholders, providers, and patients. Information is collected on attitudes, preferences, and behavior related to the operational and financial aspects of either the provision or use of health services. Findings from these activities inform policy design and promote the development of strategies to ensure the acceptance of the new policies. The findings can also provide early feedback on start-up operations as well as indicate areas in which quantitative research would be helpful. Such research will also be used to prepare a marketing strategy for Phase 2.

Focus Groups

A series of focus groups, now underway, was designed to gain insight into critical issues for the success of the FHF: willingness of providers to contract with the FHF; and willingness of families to subscribe to the pilot service delivery sites and pay the proposed fees. In addition, other planned focus groups with providers and patients in the service delivery pilot sites now operating will provide feedback to assist with the development and promotion of the FHF as the "sponsor" of the quality services delivered in those clinics.

Publications

PHR has prepared a series of technical reports that lay the foundation for the FHF. PHR technical advisors have prepared two-page Informational Briefs, Policy/Discussion Papers (Decision Briefs), and slide presentations about the pilot project, its context and aims, as well as options for the organizational development and financing of the FHF. Executive summaries of technical reports, briefs, and presentations were translated into Arabic as was the global PHR Policy Primer on "Alternative Provider Payment Methods: Incentives for Improving Delivery" (Wouters 1999).

An overview of the Health Sector Reform Program's goals and objectives and the issues to address beginning with the primary care reform was outlined in a "Question and Answer Brief" and translated into Arabic. This publication explains the health system reform context and the policy reform objectives that the FHF would help attain.

Glossary and Translation: Communication Aid for Policy Dialogue

Policy dialogue was fettered by the new concepts and language of health reform. English terminology for health policy, management, and financing did not find easy equivalents in Arabic. Language barriers increased with outreach from Cairo to pilot governorates. PHR compiled an Arabic/English glossary of both technical and non-technical terms to provide a consistent way to discuss and describe reforms, technical concepts, and policy options relevant to the primary care reform and the family health care pilot. Considerable effort went into identifying and contracting suitable Arabic/English and English/Arabic translators who could handle health policy and financing translations. The glossary is used by translators and anyone who must speak and write in Arabic about the pilot and, specifically, the Family Health Fund.

Spokespersons

Part of the marketing strategy relies on the efforts of effective "spokespersons" for the FHF at the policymaking, management, and community levels. A list of key contacts was compiled as the policy process unfolded to create a network of support for the FHF, and ensure concerned parties were not overlooked in consultative or dissemination activities. Early efforts focused on the FHF advisory committee established in the pilot area of the HIO North West Delta Branch. Successive rounds of strategic planning, consensus-building, and communications activities included additional pilot stakeholders from the MOHP and the participating facilities.

7.2 Phase 2

7.2.1 Communications and Marketing Strategy

Once the basic internal management structure and operations are in place and the FHF is "open for business," FHF marketing activities must shift to encouraging providers to contract with the FHF and patients to enroll in the pilot service delivery sites. The FHF director must select a qualified individual with experience in business marketing to develop and coordinate marketing and provider and customer relations activities. A marketing strategy needs to be developed to highlight the benefits of the FHF, with messages centered on:

> Family doctors and nurses

> Quality care and accredited facilities

> Fair and consistent fees

> Customer satisfaction and health promotion

> Sustained access to care

Public promotion of the FHF should be separate from and follow on the establishment of FHF. Hasty promotion of the FHF before it is ready to receive "customers" can risk loss of those customers (providers and patients). Before initiating marketing activities:

> The FHF should elaborate the FHF contractual arrangements with providers (policies, payment and other incentives, all other requirements).

> The FHF should set patient fee schedules and exemption policies (or alternative financing policy).

> The QI directorate should determine the accreditation status of participating facilities.

> The FHF should designate a spokesperson.

> The technical support team should designate a public relations and marketing counterpart to help develop and implement the FHF marketing, until the FHF is ready and able to recruit a qualified individual on a permanent basis.

7.2.2 FHF Marketing and Public Relations Activities

The second phase of communications and marketing activities accompanies the actual launch of the FHF. In this phase the FHF must publicize its existence and explain policies and benefits to providers and patients in the pilot district. Later communications will extend to the entire governorate and employ more media including community outreach, brochures and pamphlets, billboards, radio spots, and video. Phase 2 communications and marketing activities are discussed in terms of this timing and sequencing.

7.2.2.1 Ongoing Policy Communications

Communications already underway to support the establishment and start-up of the FHF ought to continue. Consensus-building activities should focus on financing and contracting options and issues.

Briefings and Presentations

It will be important to accompany the establishment of the FHF with formal briefings to orient FHF staff as well as key stakeholders *within* the MOHP and HIO at the central, governorate, and district levels about the new FHF and its aims, policies, and plans. These briefings and presentations should put the FHF's role in the pilot and the sector reform into clear and full perspective and win cooperation of potential "champions" for the financial, quality, and performance-based management reforms inherent in the FHF. They also help build the capacity of spokespersons to articulately speak about the FHF and answer questions.

Spokespersons

With the establishment of the FHF there will be a need for influential spokespersons, in addition to the director of the FHF, to introduce and promote the organization to diverse groups and peers and explain its purpose and benefits. Such spokespersons can also respond to critics who may see the FHF only as a mechanism to make people pay for health services that are stated as a constitutional right, however unfulfilled that right may be by deficiencies in the current system.

7.2.2.2 Marketing to Patients

Preceding and accompanying the start-up phase of the FHF, the family medicine approach should be marketed as one of the main products or services the FHF is selling. Understanding and appreciation of the value of accreditation and the integrity of the facility accreditation process must also be developed. Focus group results on patient and provider satisfaction with the pilot services,

willingness to pay and willingness to contract with the FHF will instruct a start-up marketing campaign on a limited scale.

At start-up, given the restricted area of operation and the limited pool of family doctor/nurse teams, mass media promotion is *not* warranted. Early promotional efforts must be low cost and take into account the cultural preference for verbal communication and low literacy rates in the pilot areas. The customer service function must be put in place to swiftly address complaints (see Chapter 4, Figure 7: Organization Chart 2), and the beneficiary relations representative(s) must be able to answer questions promptly and accurately.

Appropriate marketing activities include:

> Word of mouth/community outreach

> Presentations at mosques and other community centers

> Formal presentations to political and community leaders

> Simple, short flyers

> FHF brochures

> A "Family Health Day" in target communities to promote preventive health and enrollment

> Community billboards

When the capacity of the service delivery sites and FHF expands, mass media like radio and television can be added to promote the FHF.

7.2.2.3 Marketing to Providers

The FHF's image should be linked to the professional satisfaction of the providers. Providers' understanding and knowledge of the FHF will also benefit from the marketing activities directed towards patients. In addition, marketing to providers will include:

> A brochure specifically for providers

> The provider payment representative(s) at the FHF

> Q&A (question-and-answer) briefings for public, private, and NGO providers,

7.2.2.4 Marketing to Introduce Fee Collection at Pilot Service Delivery Sites

It is critical to inform rostered patients at pilot service delivery sites about the institution of proposed FHF roster and other fees. Patients must be informed of the new policy and the planned date of inception to minimize negative political fallout that could put the launch of the FHF at risk. As soon as FHF fees are set and approved for implementation and exemption policy and procedures are clarified across all participating clinics, briefing pilot service delivery site staff and patients must

begin. MOHP, TSO, TST, HIO, and FHF officials must have an implementation strategy and brief concerned staff and key political officials in the pilot area.

A focus group on willingness and ability to pay will provide some insight as to an appropriate strategy. Simple, clear explanations of the purpose of the fees and payment options, which services are covered and not covered, and the fact that the new FHF is an alternative to the old HIO and MOHP systems must be developed. People must also be informed that they will not be denied care if they opt out but that they must go to other MOHP facilities that are not participating in the pilot. Patients who stay and pay will give a true indication of patient satisfaction and the perceived value of the new health care model. Enrollment promotion (Family Health Day Fairs) in the service delivery pilot sites should take place to compensate for those who elect to drop out.

7.2.2.5 Institutional identity

A graphic identity must be fashioned for the new FHF, including a logo that is associated with "quality and security." Trust in the new FHF and the participating family health clinics is key to the success of the pilot and its expansion. Currently, all social and income strata prefer private sector services, and the FHF must be attractive enough to modify this behavior and improve the equity and access to health care for the poor.

Three variations of a logo have been developed and modified based on informal feedback solicited from 50 stakeholder representatives, ranging from MOHP and HIO policymakers and managers to providers and patients at one pilot clinic. However, the "goldstar" emblem developed by the population groups funded by USAID to certify family planning clinics may need to be incorporated into the FHF logo design. Maternal/child health and reproductive health groups at a recent coordinating meeting indicated they are likely to adopt use of the goldstar to signify quality certification for their facilities. Mass media development (brand recognition campaigns) to familiarize the public with the goldstar means the FHF should explore public perception of the goldstar and how to capitalize on this investment.

7.3 Communications and Marketing Capacity and Budget

Revision of a TSO/TST communications and marketing workplan for 2000 is underway and could incorporate FHF-specific activities in addition to those contemplated to promote family medicine and health promotion. However, a budget and human resources still need to be tied to that plan.

Once the key FHF issues and operating policies are decided, it would be preferable for the FHF to select a dedicated coordinator for marketing and customer relations who can work with advisors and the TSO/TST to develop the FHF marketing strategy and budget and start to carry out promotional activities. If not, the TST should assign a designated staff member who is exclusively responsible for coordinating the marketing work related specifically to the FHF and who works in close liaison with the FHF Director.

PHR has budgeted for the services of a writer/editor, for the development of short informational and policy/decision papers (decision briefs), for quarterly briefings and consultative policy meetings, for training in presentation skills, for the development of a video on the whole pilot project, and the series of focus groups. These activities will necessarily carry on through 2000 as the FHF develops.

As FHF development accelerates, the need for FHF flyers, brochures, banners, radio, and TV or billboard advertising will also accelerate. The inherent development, graphic, and production costs for these items and any other provider or community outreach activities the FHF would sponsor need to be factored into an FHF or TSO/TST budget. Adequate human and financial resources must then be allocated to promotion of the FHF and the public information it will need to provide.

There is already a gap in human and capital resources needed to handle the demands of various reform communications activities; such activities are important to create an environment conducive to the long-term success of the FHF. They include:

> The Minister's advocacy efforts to promote health system reforms

> Policy communications around technical issues and policy options for the service delivery, financial, and regulatory reforms embodied in the pilot; for informing the public about the execution of new policies

> Provider information and training to improve quality and implement the family medicine approach

> Consumer health education and promotion that is inherent in primary care and the reform of the system as well as the Healthy Egyptians 2010 initiative

> Marketing of the Family Health Fund

Once the FHF is established and grows, it may evaluate whether to contract for marketing services but regardless it will require a coordinator to work closely with the director on planning and executing public relations and marketing activities on many levels. It will require a budget and experienced personnel for mass media advertising (social marketing).

Table 2 summarizes the types of communication objectives and activities and the lead implementers.

Table 2. Communications and Marketing for the FHF

Activities	Phase 1: Development (1999-2000)	Phase 2: Start-up (2000)	Phase 3: Growth (2001→)
Policy Development and Strategic Planning Support (technical) *Who*: TSO,HIO,MOHP,PHR,EU	Consensus-building meetings; presentations; stakeholder interviews; focus groups; briefs and publications	→→→→→→→	Strategic management support
Advocacy Support (political) *Who*: Minister; Support: TSO, Forum, Donors	Speechwriting; press briefing materials; publications; cabinet and parliamentary presentations; internal MOHP and HIO presentations	→→→→→→→→	Establishment of Egyptian Association of Family Health Practitioners
Public Information (official facts; transparency of new institution) *Who*: FHF, QI Support: PHR, EU		Introductory report on FHF establishment and management; accreditation process, standards and accredited facilities; FHF presentations at pilot service delivery sites	Annual report; other FHF publications and MOHP web page with Accredited Provider Network List; enrollment information, etc.
Public Relations and Marketing (promotion) *Who*: FHF, TSO/TST Support: PHR,EU	Focus Groups Logo Development	Logo; focus groups; pilot provider presentations and brochure; pilot patient brochure and flyers; pilot community outreach activities and Family Health Day enrollment	Brochures; radio and TV spots using endorsements by famous personalities; billboards; video; Family Health Day enrollment (site/provider choice);
Health Promotion (education and awareness) *Who:* TSO/TST, MOHP, FHF Support: Healthy Egyptians 2010, PHR, EU, WHO		Drug awareness; Family Health Day (priority health topics)	→→→→→→→→
Pilot Communications Training *Who*: PHR, EU		How to articulate and organize FHF presentations to providers; to patients; to pilot observers	

8. Strategic Policy Planning and Development for the FHF as the Financing Agency within a Full-functioning Health Insurance System

As has been mentioned earlier in this paper, it was anticipated initially that the Family Health Fund would become the new financing agency within a full-functioning health insurance system. As such it would have collected and held all health insurance funds from the Health Insurance Organization on behalf of its beneficiaries as well as those from the Ministry of Health and Population for individuals covered by its service delivery program. Since that time, the concept of the FHF as an insurance fundholder has changed to reflect the complexities of developing and implementing new health insurance legislation to replace that which currently exists.

It is now expected that the FHF will begin to function as a *quality contracting agency* which holds only those funds collected from annual patient roster fees (i.e., fees to register with a service provider). It will use this money to pay performance incentives to service delivery sites and referral providers that meet or exceed quality indicators specified in their service contracts with the FHF.

It is important to view this more narrow mission and operational mandate for the FHF as the first step in a strategic phased approach toward the longer-term development of a full-functioning health insurance system, based upon performance-based contracting methods and measurable goals for continued improvement in the delivery of quality health care services. This perspective requires strategically managing the policy process within the Family Health Fund itself, as well as beyond FHF organizational boundaries.

Figure 11, the Policy Process, is taken from Brinkerhoff and Scribner (1999). It illustrates a conceptual framework for a policy process that has great potential to "assist the MOHP in planning and implementing policy development and a consensus-building and implementation strategy for new policies..." Although the stages in the framework appear to be sequential in nature, the process often requires parallel and iterative efforts.

As Brinkerhoff and Scribner point out, those involved in health sector reform "need to determine at which stage in the policy process they are. This can help them recognize what tasks to undertake so as to move their health sector reform efforts forward." It is equally important that a strategic management approach (see Figure 12) be used at each stage in the policy process, to bring a balance of "looking-out, looking-in, and looking-ahead issues" into goal setting, analysis, strategy formulation, strategy implementation, and monitoring.

Following are suggestions for application of the policy process framework to the longer-term development of the Family Health Fund.

Figure 11. The Policy Process

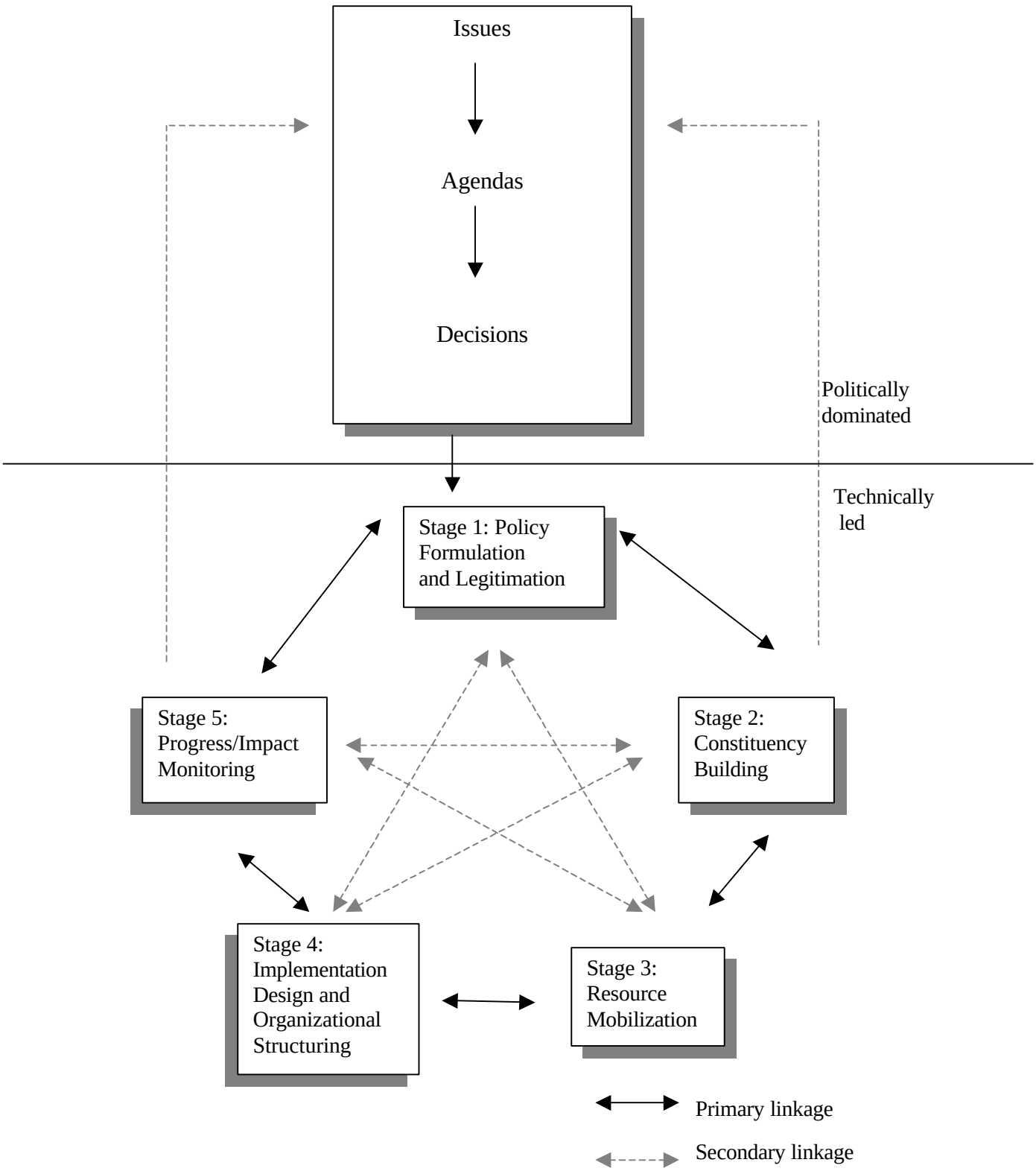
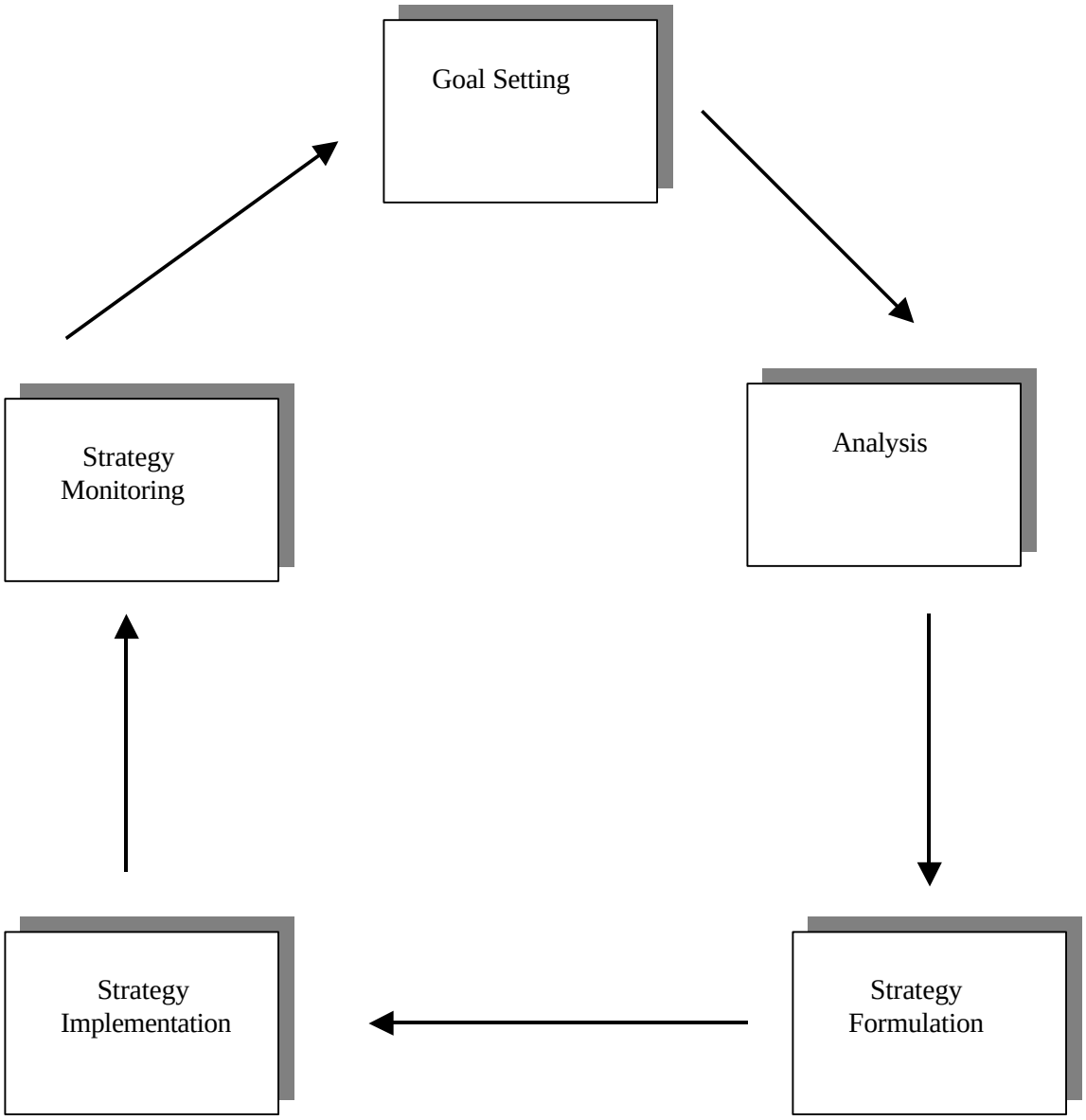


Figure 12. Elements of Strategic Management



8.1 Setting of Policy Direction

Overall direction for the 10–15 year Egypt Health Sector Reform Program was determined by the decision of the Minister of Health and Population to emphasize the development of a strong mechanism for primary health care. As indicated in Figure 11, this decision was based on identification, discussion, and assessment of major health care policy issues within the country, as well as consideration of numerous social, economic, and political agendas. The setting of policy direction for the reform was the catalyst for support of donors financially and with expert assistance given to the task of formulating and implementing the technical content of the reform policy.

USAID determined that the primary focus of its contribution to health sector reform in Egypt would be a health policy support project to model the various components of an effective system for family health care. This entails two major aspects: support for the necessary regulatory changes and feasibility testing of a care model and finance model in a pilot district. In the politically driven direction-setting phase of the policy process, the primary focus is on legal, policy, and regulatory change.

It is important to note that the implementation of the five stages of the policy process will reshape the social, economic, and political context within which future changes will be discussed and implemented. As a result, new policy issues will be identified which will require extensive political discussion and eventual resolution.

Some of the FHF-related policy issues that stakeholders already have identified are listed in Table 3.

Table 3. FHF-related Policy Issues

Short-term	Long-term
Legitimize through ministerial decree the FHF quality contracting agency and a fiduciary Board of Trustees	Determine whether role of FHF continues as a quality contracting agency or evolves into a full health insurance fundholder as pilot projects are implemented in other governorates
Devise approaches to collect patient/beneficiary roster fees for registration with a service provider, as well as regulations governing distribution of collected fees for FHF operations and provider payment incentives	Formulate and implement legislation to permit full health insurance fundholding by an institutionally autonomous FHF governed by an independent, stakeholder-represented fiduciary Board of Trustees
Develop and implement policies concerning collection of user fees and co-payments during the period of the pilot project	Define and implement new roles and associated responsibilities for MOHP and HIO
Determine how to assess and make decisions based upon health-related measures tied to the current basic benefit package	Identify sources of funding to sustain FHF operations after the term of the pilot project
	Develop and implement policies concerning collection of user fees and co-payments after the end of the pilot project, in other governorates as additional pilot projects are implemented, and in the longer-term case of an expanded benefit package
	Determine how to expand the basic benefit package while sustaining high quality care and managing cost to the health system

8.2 Stages of the Policy Process

8.2.1 Step 1: Policy Formulation and Legitimation

Brinkerhoff and Scribner describe formulation of the technical content of the policy and making the policy legitimate as two essential activities in this first stage in the policy process. A number of examples designed to promote and support these activities are described in Chapter 2 of this technical report. They include information seminars, focus group discussions, policy/discussion papers, regular meetings with major stakeholders, and participatory work planning sessions.

In order to specify the technical content of policies necessary for the longer-term development of the FHF as a full health insurance fundholding organization, technical analyses need to be complemented by expanded stakeholder participation, through steps such as:

> Immediately upon implementation of the FHF as the quality contracting agency, involve the senior management team in sessions to explain the pilot project and details of the role of the FHF within it.

> Ensure that the newly appointed Board of Trustees and the High Committee on Health Insurance have the same understanding as well as a solid grasp of the particular nature of their roles and the relationship among them.

> Convene meetings with FHF management, the Board of Trustees, and the High Committee for Health Insurance to begin to build a strong expanded team and also to develop a process for ongoing discussions among the three groups. These discussions will include relating the strengths and weaknesses of FHF operations to achievement of the pilot project goals. The expanded team will also examine larger social, economic and political issues in the contextual environment, which could impact sustainability of the FHF and quality primary health care. Members will be encouraged to identify key strategic policy development issues.

> Introduce the policy process to the expanded team members and build appropriate capacity within each of the three groups to manage the tasks associated with their place within it.

8.2.2 Step 2: Constituency Building

Stage 2 in the policy process is specifically directed at building understanding and active support among groups and individuals who will be impacted by and can influence the successful implementation of the reform. Chapter 2 in this report describes many of these groups of people and illustrates them in Figure 1 as part of the pilot project system. In addition, it outlines many of the activities designed to foster their commitment and involvement. If development of the FHF as a true health insurance organization is to occur, there will need to be additional constituency-building activities.

Active and informed community participation is essential to the effective functioning of the pilot model and the FHF. Once the FHF is established, beneficiaries will need to select a facility at which to roster, pay the fostering fee, and, on an annual basis, indicate satisfaction by re-rostering or dissatisfaction by rostering with another service delivery site. Community participation will be facilitated if beneficiaries understand that their roster fees finance the incentive payments to providers

to reward them for quality performance, and that the FHF is the organization responsible for administration of their fees. That understanding will reinforce the relationship between rostering fees and quality services, encouraging service providers to interact more thoughtfully with beneficiaries and beneficiaries to more actively express their opinions. Chapter 7 provides specific detail on communication approaches to increase community understanding and participation. With more participation, the viewpoints of the community will influence longer-term policy issues as the reform proceeds and the content of policies developed to support and sustain a fully independent FHF financing agency.

One of the important aspects of this stage in the policy process is reduction or deflection of opposition to the reform. The Alexandria pilot project system includes service delivery participation by practitioners from the private and NGO sectors in addition to those from MOHP and HIO. Private and NGO sector participation are essential to ensure adequate coverage and choice for beneficiaries as well as to provide the necessary competition to encourage continuous quality improvement. However, it is important to recognize that improved service delivery quality in MOHP and HIO pilot sites and the associated potential for them to attract paying customers away from the private sector may be perceived as threatening. Building interest and active involvement among these constituents will be a challenge for the FHF.

This challenge will become larger and even more critical as the FHF moves toward becoming an autonomous health insurance agency. Private and NGO sector service providers have the potential to greatly influence policy issues, direction, and implementation. Some of the issues that will become apparent are:

> Using MOHP and/or HIO funds to pay incentives to private and NGO sector service providers

> Ensuring universal coverage for pensioners, the poor, students, widows, if/when MOHP and HIO abandon their insurance provider roles

> FHF contracting with, purchasing services from, and paying incentives to service delivery sites in all four sectors

8.2.3 Step 3: Resource Mobilization

Brinkerhoff and Scribner point out that “health sector reform demands financial, technical, and human resources. Often these resources are inaccessible (allocated to someone else’s budget), unavailable (assigned to other priorities and programs), or non-existent (no appropriately skilled staff).”

The current plans to implement the FHF as a quality contracting agency have identified needed resources and in some cases suggested approaches to obtaining them. In many instances donors will finance or support necessary resources, at least for the period of the pilot project. It will be critical that those locally responsible for sustaining the FHF and the service delivery sites are aware of the need to plan and budget for, create incentives to sustain, and develop new sources for obtaining necessary resources.

As has already been mentioned, one of the greatest resource challenges will be funding for the current and future operations of the Family Health Fund and the health care system as a whole. This

will become particularly critical if/when MOHP and HIO change their current roles as health insurers, financing agencies, and health care providers.

Another resource mobilization factor critical to sustain and expand the strategy for primary care from Alexandria to the rest of the country is the development of new local reform champions with the necessary understanding, influence, energy, and commitment to the overall direction of the reform as well as to its strategic policy requirements. Part of the capacity-building that will be needed to move the FHF toward its full potential within a functioning health insurance system includes targeted training and coaching in approaches to strategic policy planning and implementation. The experience and skills developed by local stakeholders deeply involved in these activities during the period of the Alexandria pilot project will be valuable resources that should be mobilized as needed.

8.2.4 Step 4: Implementation Design and Organizational Structuring

Stage 4 in the policy process is associated with three major activities:

> Design and implement new arrangements or structures, or modify existing ones

> Involve a wide range of stakeholders to support implementation

> Manage the transition to help individuals and groups adapt and function effectively

This technical report has described recommendations, current activities and processes, as well as planned actions that are aspects of this fourth stage of the policy process. Chapter 2 outlines a number of stakeholder involvement activities that have focused on the design and implementation of the new service delivery pilot site model and the design of the yet-to-be implemented Family Health Fund.

The FHF will be unique in Egypt, in terms of its mandate and the manner in which it functions internally according to specific accountability and behavioral principles. In effect, the FHF will create an organizational culture that explicitly links performance to reward and recognition, both inside and outside its organizational boundaries. Successful implementation of the FHF, even in its initial limited role as a quality contracting agency, will require extensive training and coaching of the management team in both the technical and leadership aspects of its role. This includes coaching in strategic management, the elements of which are presented in Figure 12.

It is also crucial that the information, control, and management systems of the FHF be supportive of and consistent with, this performance-based philosophy. A number of activities have been recommended in this regard. (Refer to Chapter 4 and Chapter 6 for more detail.)

Another new arrangement essential to the effective functioning of the pilot project is the fiduciary Board of Trustees. Its role, responsibilities and relationship with the director of the Family Health Fund are described in great detail in chapter 3.

8.2.5 Step 5: Progress/Impact Monitoring

The fifth stage in the policy process is progress/impact monitoring. The High Committee for Health Insurance, with input from the fiduciary Board of Trustees and the FHF management team, will play a key role in using the lessons learned from the pilot project to identify strategic policy issues, involve key stakeholders in policy discussions, and determine strategic policy directions. This

function will be especially critical if the Family Health Fund is to become an autonomous insurance agency within a full functioning health insurance system, thereby fulfilling one of the major goals of the long-term Health Sector Reform Program.

Chapter 6 of this technical report outlines the contribution of the FHF-MIS to the information, control, monitoring and evaluation, and performance-incentive payment functions of the FHF. The reports produced by the FHF-MIS will provide essential data for learning and improvement to the service delivery sites, the FHF management team, the fiduciary Board of Trustees, and the High Committee for Health Insurance. In addition, other major stakeholders will receive valuable information about the impact of various performance contracting strategies on numerous aspects of quality service delivery including cost, number and cost of specialist referrals, number and cost of prescriptions, patient wait times, and overall patient satisfaction. Information will also be available concerning patient usage of the various services provided within the current basic benefit package, as input to development of strategies and policies to extend the types of services included.

The Alexandria pilot has been described as a demonstration project. As such, close monitoring of the progress and impact of all aspects of the project are critical to ensure that successes are duplicated in other governorates, mistakes are avoided, implementation issues are identified and learning is built into other governorate pilot projects as well as into the expansion of universal coverage for primary health care to all of Egypt.

9. Conclusions: Lessons/Issues for Rollout to Other Pilot Governorates

The establishment of the Family Health Fund as the quality contracting agency is the final crucial component of the family health pilot project. It will model many features to demonstrate how such an agency can operate effectively at the governorate level. Some of these features are:

> Fiduciary oversight of the FHF by a Board of Trustees

> Representation of multiple stakeholders in a Board of Trustees

> Sound organizational and accountability principles

> An organizational culture that explicitly links performance to reward and recognition, both inside and outside its organizational boundaries

> Clear separation of FHF financial and contracting functions from service delivery functions

> The introduction of an encounter form to collect data for administration of contracting strategies and monitoring of service quality

> A management information system that provides accurate data processing for contract administration

> Standard contracts that provide transparency to contractees by clearly specifying performance requirements

> FHF incentive payments to service delivery staff based on achieving performance targets

> Inclusion of patient satisfaction criteria as a basis for FHF incentive payments

The Alexandria FHF model must be evaluated a few months after it has been fully implemented to determine if the organizational model and operational systems used will be replicable in the other pilot governorates, as well as to the balance of the country. It may be necessary to make adjustments to the organization or the contracting and operational methodology used in the Alexandria FHF to meet the particular circumstances of other governorates. The evaluation phase will be important in this regard.

The following is a proposed accelerated timeline for operationalizing the FHF:

December 1999:	The Minister of Health and Population signs decree to establish the FHF and its contracting activities with service delivery pilot sites
January 2000:	Minister approves financing mechanism for the pilot project
January 2000:	FHF director and staff are selected

January 2000:	Board of Trustees for FHF appointed
mid-January 2000:	Management development of FHF staff starts by PHR
end-January 2000:	PHR works with FHF to devise contracts, ready to apply to service delivery pilot sites
end-January 2000:	PHR/TSO orientation seminar held for Board of Trustees and FHF staff
end-January 2000:	Prototype MIS for FHF devised, tested, and operational
February 2000:	Operational procedures prepared for the FHF
February 2000:	Private and NGO sector service delivery pilot sites join the program
March 1, 2000:	Effective date for performance-based incentive contracts by FHF with assistance of PHR
April 1-30, 2000:	Dates for collection of encounter data for first incentive payment by FHF
May 9, 2000:	Last date for submission of April encounter data to the FHF
May 10-31, 2000:	Analysis of encounter data by FHF with assistance of PHR, production of FHF reports
June 1, 2000:	First incentive payment by FHF to staff at service delivery pilot sites with reports provided for management review at service delivery pilot sites

Once the FHF is fully operational, crucial costing data of the family health model will be available that will permit comparisons between service delivery pilot sites, as well as between the various sectors that participate in the program. Costing analyses, combined with encounter data on utilization of services, will permit actuarial projections to be made on the true cost of providing family health services on a universal basis within a governorate or at the national level.

Such data and analyses will be invaluable for planning for the future of the pilot model, both in terms of expanding coverage to more beneficiaries and in terms of the possibility of expanding the basic benefits package to encompass more comprehensive service coverage. Proper premium rates may then be determined that will ensure that certain services, such as family planning and immunizations, may be provided free of charge because of risk pooling in a universal system. Risk pooling will also permit the GOE to provide premium free coverage to families that have incomes below a pre-determined poverty level.

Another significant outcome of the establishment of the FHF will be the change in the future role of HIO as it separates its service provider role from the purchasing role that is assumed by the FHF. This will have substantial organizational, legal, and financial implications, including defining a new organizational mandate for HIO, with associated roles and responsibilities, appropriate organizational restructuring, and capacity-building.

The evaluation of the Alexandria pilot project for family health will be carefully considered by the European Union, the World Bank, and other donors as they use the lessons learned from the pilot

to plan and implement expansion of the model, to other governorates and nationally, in the Egyptian health sector reform project.

Annex A. Translation of Ministerial Decree Establishing the Family Health Fund

TRANSLATION OF DECREE

Arab Republic of Egypt
Ministry of Health and Population
The Minister

The Ministerial
Decree No. 294
of the year 1999

The Minister of Health and Population

Having taken note of the Constitution and the following laws and decrees:

Law No. (**79**) of the year **1975** amended by Law No. (25) of the year 1977 on Social Insurance

AND The Presidential Decree No. (**1209**) of the year **1964** promulgating the establishment of the Health Insurance Organization and its different divisions

AND The Presidential decree No. (**2323**) of the year **1967** on authorizing the Health Insurance Organization to provide medical and pharmaceutical services for the uninsured on a fee for service basis.

AND The Presidential decree No. (**254**) of the year **1997** on the agreement between the GOE and USAID that represents the USA for the donation for technical support for the Health Sector Reform Program.

AND The Presidential decree No. (**65**) of the year **1999** on the financing agreement between the GOE and EC concerning the Health Sector Reform Program.

AND The Prime Ministerial decree No. (**10**) of the year **1981** on providing medical services and treatment for the families of the insured and pensioners in Alexandria by the Health Insurance Organization.

AND The Ministerial decree No. (**282**) of the year **1975** on user fees required for receiving medical services by the Health Insurance Organization.

AND The Ministerial decree No. (**804**) of the year **1981** on the regulations of providing medical services and treatment for pensioners and families of the insured.

On the recommendation of the High Committee for the Family Health Fund, the Minister decided to:

Article "One"

Open an account in a Bank, called the "Family Health Fund" for the Health Sector Reform Program.

Article "Two"

HE the Minister or whomever he delegates hires a Family Health Fund Director and staff for the operations of the Family Health Fund.

Article "Three"

By a decision of the Minister or whomever he delegates, a Board of Trustees is appointed to overview the Family Health Fund's work. The formation of the Board is as follows:

- ✓ Representative from the Health Sector in the Pilot Project Governorate
- ✓ Representative from HIO in the pilot project Governorate
- ✓ Representative from the TSO
- ✓ Representative from the community and the NGO and private sector
- ✓ Representative from the Governorate office of the Pilot Project
- ✓ Any other representative that the Minister of Health and Population wishes to add to the Board of Trustees

Article "Four"

The name of the financial account for the Fund will be:

- ✓ Family Health Fund for The Health Sector Reform Program

Article "Five"

The Fund is financed through:

- ✓ Money collected for receiving the services
- ✓ Any other sources that the Minister determines can be added to the Fund

Article "Six"

The Family Health Fund has the right to contract with all government and non-Government organizations to offer basic health services and any other kind of health services

Article "Seven"

The Family Health Fund is responsible for the following:

- ✓ Paying incentives for staff working in the Pilot Sites based on rates of performance and quality of services
- ✓ Paying for its own administrative costs
- ✓ Paying for any other responsibilities that the Minister of Health and Population determines

Article "Eight"

The Family Health Fund has the right to invest its reserves

Article "Nine"

All the agencies involved should execute this decree starting from the date it is issued.

Dated December 29, 1999

Signature

(Professor Doctor Ismail Salam)
Minister of Health and Population

Annex B. Medical Encounter Form

Governorate #: 02
District #: 01
Family Health Center/Unit #: 01

Medical Encounter Form

Patient #:		Social S #:	National #:	HIO #:
Patient name:	First:	Middle:	Family Name:	
Date of Birth:	Gender: M F			
Family Clinic #:	Family Physician Name:			
Date:	Time in:	Time Out:		

Diagnosis

Diagnosis	Code

Procedures

Medical Visit		**LAB Visit** Name	Code	**X-RAY Visit** Name	Code
Brief: under 10 minutes					
Intermediate: 10-20 m					
Extended: Over 20 m					
Referred Patient to					

Pharmacy

	Drug Name	**Quantity**	**Form**	**Duration**	**Doses/d**
1.					
2.					
3.					
4.					
Comments					

Doctor's Signature: Nurse Signature:

Annex C. Referral Form

Governorate: Alex
District: Shark
Family Health Center/ Unit:Suef

Referral Form

Patient #:	Social S#:	National #:	
Patient Name:	First:	Middle:	Family Name:
Date of birth:	Gender: M	F	

Family Clinic #: | Referring Family Physician Name:

Date: | Encounter reference #:

ICD 10 code

Physical Examination:

Lab Investigation:

X-ray:

Reason for Referral:

	Specialty	Name of specialist
FHC		
Other Special		
Hospital N		

Doctor's Signature:

Report from Specialist/ hospital to FP

Diagnosis:

Results of Investigations

Treatment/Prognosis:

(use reverse for additional information)

Annex D. List of Proposed FHF Encounter Reports

Report 1 Unit Comparison report

Item	FH Unit A	FH Unit B	FH Unit C	All
1. # of visits/ doctor				
2. # of visits > 20 minutes				
3. Referral % *# of visits with referrals / total # of visits*				
4. X-Ray % *# of visits with request for X-ray / total # of visits*				
5. Lab % *# of visits with request for lab tests / total # of visits*				
6. Drugs % *# of visits with request for drugs / total # of visits*				
7. Average wait time for visit				

Volume Reports

Report 2 Family Practice Roster Volume

Item	Current month			Previous month			Y-T-D		
FP Roster	1	2	3	1	2	3	1	2	3
# of visits									

Report 3 Family Practice Team Volume

Item	Current month						Previous month						Y-T-D					
FP Team	1a	1b	2a	2b	3a	3b	1a	1b	2a	2b	3a	3b	1a	1b	2a	2b	3a	3b
# of visits																		

Note: team here means a physician and nurse team. The number refers to the FP room #. The letter “a” or “b” is assigned to every team because two teams share a roster in two shifts: “a” is the am shift, “b” is the pm shift.

Report 4 Diagnosis Volume

Item	Current month			
	Total # of visits	Family Practice Roster		
		1	2	3
Top 10 Diagnosis - - -				

Item	Previous month			
	Total # of visits	Family Practice Roster		
		1	2	3
Top 10 Diagnosis - - -				

Report 5 Age group Volume

Item	Current month				Previous month				Y-T-D			
	Total # of visits	Roster			Total # of visits	Roster			Total # of visits	Roster		
Age group		1	2	3		1	2	3		1	2	3
0-5 5-15 15- -												

Report 6 Family Practice Team Referral Volume

Item	Current month						Previous month						Y-T-D					
Family Practice Team	1a	1b	2a	2b	3a	3b	1a	1b	2a	2b	3a	3b	1a	1b	2a	2b	3a	3b
1.# of referrals 2.Referral %																		

Ancillaries

Report 7 Usage of Ancillaries

Item	Current month						Previous month						Y-T-D					
Family Practice Team	1a	1b	2a	2b	3a	3b	1a	1b	2a	2b	3a	3b	1a	1b	2a	2b	3a	3b
1. # of X-ray																		
2. X-ray %																		
3. # of lab tests																		
4. Lab %																		
5. # of prescriptions																		
6. Drugs %																		

Wait time

Report 8 Wait time report

Item	Current month						Previous month						Y-T-D					
Family Practice Team	1a	1b	2a	2b	3a	3b	1a	1b	2a	2b	3a	3b	1a	1b	2a	2b	3a	3b
1. Wait time for Dr.																		
2. Dr. visit length																		
3. Total time at facility																		
4. % of visits with wait time over 40 minutes																		

Drugs Usage

Report 9 Drugs usage

Item	Current month		Previous month		Y-T-D	
Drugs class	# of prescriptions	# of prescriptions/ visit	# of prescriptions	# of prescriptions /visit	# of prescriptions	# of prescriptions /visit
- - -						

Team report

Report 10 Family Practice team report

Item	Current month		Previous month		Y-T-D	
	FP team 1a	Team average	FP team 1a	Team average	FP team 1a	Team average
1. Total # of visits						
2. # of brief visits						
3. # of intermediate visits						
4. # of extended visits						
5. Referral %						
6. Lab visits %						
7. Drugs %						
8. Drugs cost LE						

Annex E. Glossary

Co-payment: patient contribution towards the cost of prescription drugs. Fees collected are used to ensure a steady supply of necessary drugs.

Family Health Fund: the quality contracting agency that will collect roster fees and pay incentives to service delivery pilot site staff for achieving performance standards. Eventually the FHF will evolve into a full-functioning health insurance agency.

Family Practice Room: The examining room where the FP team sees patients: two FP teams during two shifts share this room

Family Practice Team: a team consisting of one family doctor and one family nurse seeing patients together in the same examining room either in the morning or afternoon shift. Each team provides health care primarily to its roster of 600 families (3,000 individuals). Two family practice teams share two rosters of 1200 families.

Governorate: similar to a state or a province, the political and administrative division of Egypt into 28 geographical units

High Committee: the High Committee for Health Insurance, the policy-making body for health insurance consistency, chaired by the Minister of Health and Population

Roster: a list of 600 families (approximately 3000 patients) registered with a family practice team

Roster fee: an annual membership fee charged for each person who registers on the roster of a family doctor/nurse team in the pilot project. This fee may be paid directly by the person or may be paid on behalf of the person: for example, it may be paid by HIO on behalf of the insured, or by the MOHP on behalf of those assessed as poor.

Service fee: charges for laboratory investigations, x-rays, etc.

Technical Support Office: a department of the MOHP designated by the Minister to be responsible for coordinating health reform

Technical Support Team: the team appointed to facilitate implementation of the family health pilot project in a governorate

User fee: fee per visit (same as visit fee)

Visit fee: fee per visit (same as user fee)

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